

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B'Day*

CERTIFICATE OF DEATH

Reg. Dist. No.

12203
2160

1. PLACE OF DEATH:

County *Montgomery*City or town *Takoma Park, Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *5 months*

Hospital, institution, or street address where death occurred:

805 Maple Ave.

How long in hospital or institution?

3. (a) FULL NAME

*Hattie Baernstein*4. Sex *female*5. Color or race *white*6.(a) Single, married, widowed, or divorced *widowed*6.(b) Name of husband or wife *Daw S. Baernstein*7. Birth date of deceased (mo., day, yr.) *July 15, 1868*6.(c) If alive, give age *—* years8. AGE: Years *78* Months *5* Days *11* If less than one day *hrs. min.*9. Birthplace *San Francisco, Calif.*
(Town, county, and state)10. Usual occupation *housewife*11. Industry or business *—*12. Name *George Enrichet*13. Birthplace *Germany*14. Maiden name *Anna Kosche*15. Birthplace *Germany*16. Informant *Mr. Harry Baernstein*Address *4611 Highland Ave. Bethesda*17. Cremation *—* Date thereof *12/30/46 Md.*(Burial, cremation, or removal. Which?) *(month) (day) (year)*Cemetery or crematory *Cedar Hill Cemetery*Location *Maryland*18. Funeral director *Wm. Parker Humphrey*Address *Bethesda, Maryland*19. *12/28 1946* 3pm E. James
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Wisconsin* County *—*City or town *Milwaukee*
(If outside city or town limits, write RURAL and give nearest town)Street No. *2431 W McKinley St.*

(If rural, give LOCATION)

2.(a) If veteran, name war *—*3. (b) Social Security Number *—*

MEDICAL CERTIFICATION

20. DATE OF DEATH *December 26 1946* at *145 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 7 1946 to *Dec. 26 1946*and that I last saw her alive on *December 26 1946*

Immediate cause of death

*Hypostatic pneumonia*Due to *Cardio-vascular - renal disease*

DURATION

*4 days**10 yrs**or more*Due to *—*Other conditions *Progressive spinal muscular dystrophy about 2 yrs.*
(Include pregnancy within 3 months of death)Major findings of operations *—*Date of op. *—*Autopsy results *—*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *—* Date of *—*Where did injury occur? *(City or town)* *(County)* *(State)*Injured at home, farm, industry, public place (where?) *—*Means of injury *—* Injured at work? *—*23. SIGNATURE *Katharine A. Chapman M.D.* M. D. or otherAddress *20 West Baltimore St. Kensington, Md.* Date signed *12/26/46*

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2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 129-10

CERTIFICATE OF DEATH

Reg. Dist. No. 12216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 11 weeks

Hospital, institution, or street address where death occurred:

home; 11, 11th Valley View Avenue

How long in hospital or institution?..... 11 weeks

3. (a) FULL NAME

BATES, Steven Lancaster

4. Sex

male

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife.....

.....(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

23 Sept. 1946

8. AGE:

Years

Months

Days

If less than one day

2

22

hrs.

min.

9. Birthplace..... Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name..... Phillips L. Bates

13. Birthplace..... Tenn.

14. Maiden name..... Legare Womble Bates

15. Birthplace..... S.C.

16. Informant..... father: Phillips L. Bates

Address 11, 11th Valley View Ave., Kensington, Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... 12-16-46

(month) (day) (year)

Cemetery or crematory.....

Location..... Orangeburg, S.C.

18. Funeral director..... W. W. Chambers

Address 1100 Chapin St., N. W., Wash., D.C.

19. 12-16-46 Mary Charlotte Smith
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Mont

City or town..... Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 11, 11th Valley View Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Dec 1-1946 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Self Med Exam Case 19..... to..... 19.....

and that last saw h..... alive on..... 19.....

Immediate cause of death.....

Abortion, Self pruning
accident

DURATION

13 hr 45 min

Due to.....

Due to.....

Other conditions Multiple Congenital anomaly
especially of heart

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Decedent Date of 12-16-46

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE..... Frank J. Broschart

470 N. E. 2nd Street
Gainesville, Md.

M. D. or other 12-16-46

Date signed

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DEC 23 1946

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2-2160- 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

CERTIFICATE OF DEATH

12205
2230
Reg. Dist. No.

1. PLACE OF DEATH

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Donna Laurain

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Married
Emile Laurain

6.(b) Name of husband or wife.....

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Oct 16 1864

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

Tony Cochran

FATHER

12. Name.....

Belgium

13. Birthplace.....

Unknown

14. Maiden name.....

Belgium

15. Birthplace.....

Mrs Lucille Parish

16. Informant.....

11 Sycamore Ave Takoma Park

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

Back River - Mich.

18. Funeral director.....

Address.....

19. 12/28 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

12/28 1946 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/28 1946 to Dec 28 1946

and that I last saw her alive on 12/18 1946

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

3 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

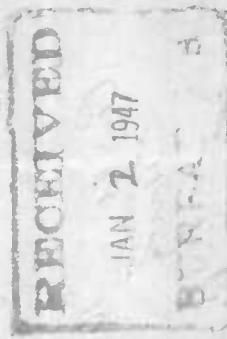
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....



Released by Dr. Brochart (Corneil)

~~Dr. Brochart~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of mother's maiden name and the addition of date of birth is shown on G 108 1/13/47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 140

12296

Reg. Dist. No. 2140

CERTIFICATE OF DEATH**1. PLACE OF DEATH:**

County Montgomery County Maryland
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAMEJohn D Bland Jr.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed

8. (b) Name of husband or wife

Julia F. Bland

7. Birth date of deceased (mo., day, yr.)

Nov. 20, 1874

8. (c) If alive, give age years

8. AGE: Years

72

Months

0

Days

10

If less than one day

hrs.min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual occupation

Civil Eng.

11. Industry or business

District Government

MOTHER FATHER

12. Name

Edward Bland

13. Birthplace

King George Co. Virginia

14. Maiden name

Mary Frances Dunn / Mary Daily

15. Birthplace

Ireland

16. Informant

Julia May Bland (Daughter)

Address

9105 Fairview Road

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof Dec 4, 1946

(month) (day) (year)

Cemetery or crematory

Mount Olivet

Location

Washington D.C.

18. Funeral director

The S.H. Hines Co.

Address

2901 14th St. NW.

19. Dec 1

1946

(Date rec'd by registrar)

Josphine McShaeffer**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Montgomery County Silver Spring
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9105 Fairview Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number**MEDICAL CERTIFICATION**

20. DATE OF DEATH

Dec 11946 at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19, 1946, to Dec 1, 1946and that I last saw him alive on Nov 30, 1946

Immediate cause of death

Coronary heart disease

DURATION

5 days

Due to

Due to

Other conditions

Hypertension

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

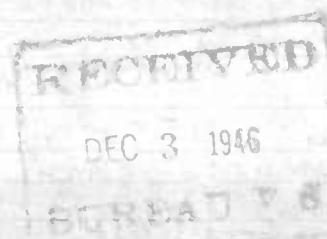
M.D. or other

John R. Andrews M.D.Silver Spring Md. Date signed Dec 1, 1946

MISSOURI STATE DEPARTMENT OF MAIL

CHIEF OFFICE OF DEVALUATION

AT LEADERSHIP, L. M. D.



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9d

12207

CERTIFICATE OF DEATH

Reg. Dist. No. 2230

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

15 Sherman Avenue

How long in hospital or institution?.....

3. (a) FULL NAME

HENRIETTA BLOOM

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	widowed

6. (b) Name of husband or wife Exxx Simon Bloom

7. Birth date of deceased (mo., day, yr.) June 13, 1870

8. AGE: Years	Months	Days	It less than one day
76	6	14	hrs. min.

9. Birthplace Nova Scotia
(Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business

12. Name John Waters

13. Birthplace Ireland

14. Maiden name Anne Suffield

15. Birthplace Ireland

16. Informant Mrs. Ruth Boyle, daughter

Address 15 Sherman Ave., Takoma Park, Md.

17. Exemation Date thereof Dec. 30, 1946
(Burial, cremation, or removal. Which?)

Cemetery or crematory Cedar Hill Crematory
Location Gaithersburg, Md.

18. Funeral director Warren E. Pamphrey

Address 8434 Ga. Ave., Silver Spring, Md.

19. Dec. 30 1946 J. H. M. D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Sherman Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1946 at 11:30 P.M.

21. CERTIFY that death occurred on the date above stated: that I attended deceased from November 1944 to Dec. 27 1946 and that I last saw her alive on Dec. 26 1946.

Immediate cause of death Cardiac dilatation

Due to Intracranial hemorrhage

Due to general debility

Other conditions general debility

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. A. Shannon Jr. D

M. D. or other

Address 13 Carrollton Date signed

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REF ID: A3

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1920

CERTIFICATE OF DEATH

Reg. Dist. No. 22-31

12268

1. PLACE OF DEATH:

County..... Montgomery
City or town..... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

since birth

Hospital, institution, or street address where death occurred:

(Home) 700 Chaney Dr.

How long in hospital or institution?

3. (a) FULL NAME

Cynthia Lynn Boatright.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

fe. wh. Baby

6.(b) Name of husband or wife..... none

7. Birth date of deceased (mo. day, yr.) may 13th 1946
6.(c) If alive, give age years8. AGE: Years Months Days If less than one day
— 7 14 hrs. min.B. Birthplace Takoma Park, Montgomery Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Lucian Haynes Boatright.

13. Birthplace Calhoun Ky.

14. Maiden name Helen Louise Gossett.

15. Birthplace Evansville, Ind.

16. Informant parents: 700 Chaney Dr

Address Takoma Park Md.

17. Burial Date thereof Dec 29, 1946.
(Burial, cremation, or removal, Which) Cemetery or crematory

New York Memorial Cem

Location Ridge Road Hyattsville Md.

18. Funeral director Arthur T. Allen

Address 254 Carroll St., Takoma Park, D.C.

19. 12/27/46 18. Registrar
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No.... 700 Chaney Dr.
(If rural, give LOCATION)

2.(a) If veteran, name war..... No

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13th 1946 to Dec 27 1946.

and that I last saw her alive on Dec 26 1946.

Immediate cause of death dehydration due to rupture of meningocele on lower part of back.

DURATION

10 days

Due to

Also had bronchopneumonia

1 week

Other conditions Hydrocephalus and birth

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Rush Standard M.D.

M. D. or other

Address 7906 Georgia Ave Date signed 12-27-46

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52-6 X

12209

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH: *Montgomery*
 County *6409 Florida St.*
 City or town *Chevy Chase Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *10 yrs.*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*EDMUND HEYWARD Bowly*4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *widowed*6. (b) Name of husband or wife *LUCY AGNES Bowly*
*DECEASED.*7. Birth date of deceased (mo., day, yr.) *OCT. 15TH 1854*8. AGE: Years *92* Months *2* Days *13* If less than one day
 — hrs. — min.9. Birthplace *N.Y. CITY*
 (Town, county, and state)10. Usual occupation *Retired*

11. Industry or business

12. Name *Edmund Bowly*13. Birthplace *BALTIMORE Md.*14. Maiden name *JANE Heyward*15. Birthplace *SOUTH CAROLINA*16. Informant *MR. LAWRENCE Bowly*Address *6409 Florida St. Ch. Ch. Md.*17. BURIAL Date thereof *12-30-46*
 (Burial, cremation, or removal—Which?) *(month) (day) (year)*Cemetery or columbarium *ST. PETERS Balirar*Location *JEFFERSON Co. W. VA.*18. Funeral director *Wm. Reuben Humphrey*Address *Bethesda, Maryland*19. December 29, 46
 (Date rec'd by registrar)20. M. D. or other *Dr. E. J. Edges*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *MONTG.*City or town *Chevy Chase*
 (If outside city or town limits, write RURAL and give nearest town)Street No. *6409 Florida St.*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *27 decemb. 1946 at 4:00 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1938* to *1946*, to *4:00 PM 12-28-1946*and that I last saw him alive on *Deceased on A. Arrived*.

Immediate cause of death

*Carcinoma of urinary
bladder*

DURATION

2 yrs.

Due to

Due to

Other conditions *Acute myocardial infarction 5 minutes.
Senility, generalized arteriosclerosis (total).*
 (Include pregnancy within 8 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other *Howard Black Jr. M.D.*
 Address *3921 Ingman St. Wash. D.C.* Date signed *12-28-46*

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

12210
Reg. Dist. No. 217

1. PLACE OF DEATH:

County... Montgomery
City or town... Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital

How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. R# 3 - Oakdale
Loc. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Britton

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

8.(b) Name of husband or wife.....

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 15, 1946

8. AGE: Years Months Days If less than one day
2 hrs. min.

9. Birthplace... Olney, Montgomery County, Md.
(Town, county, and state)

10. Usual occupation... Doctor

11. Industry or business.....

12. Name... George Britton
13. Birthplace Kentucky

14. Maiden name... Mary Bowlin

15. Birthplace Jonesville, Virginia

16. Informant... Hospital record

Address.....

17. Burial Date thereof Dec 17 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Martin's Farm

Location... No. Oakdale Rockville P.T.D.

18. Funeral Director... George Britton Father

Address... R#3 Rockville Md

19. Date rec'd by registrar... Dec 17 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1946 at 21:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1946 to Dec. 17 1946 and that I last saw him alive on Dec. 17 1946.

Immediate cause of death.....

Prematurity

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?.....

23. SIGNATURE Richard A. Yates M.D.

M. D. or other

Address... Sandy Springs, Md. Date signed 12/17/46

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DEC 30 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 184

12211

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County... Montgomery
City or town... Potomac

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

3. (a) FULL NAME

Mr. Albert Maurice Burdette

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife... Mrs. Estelle Burdette

7. Birth date of deceased (mo., day, yr.)

January 8, 1909, alive at age 38 years

December 26, 1946

8. AGE: Years Months Days If less than one day

37 11 28 hrs. min.

9. Birthplace... Woodfield, Montgomery Co. Md.

(Town, county, and state)

10. Usual occupation... Carpenter

11. Industry or business

12. Name... John J. Burdette

13. Birthplace... Maryland

14. Maiden name... Cora King

15. Birthplace... Woodfield, Maryland

16. Informant... Hospital records

Address

Burrat Date thereof Dec 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Wesley Grove and

Location

Woodfield, Maryland

18. Funeral director

J.W. Barber

Address

LaGhorsville, Maryland

19. Clerk 26 1946 Hertwicks Lawyer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

For newborn infants give residence of mother
State... Maryland County... Montgomery

City or town... Gaithersburg (If outside city or town limits, write RURAL and give nearest town)

Street No... Woodfield - Rd #1

(If rural, give LOCATION) 18

2.(a) If veteran, name war.

3. (b) Social Security Number

218-12-7833

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 26 1946 at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

deceased to cause of death

and that I last saw him alive on

Immediate cause of death

Handgun & shot

Due to: shot gun wound in liver

Rt abdomen

Due to:

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

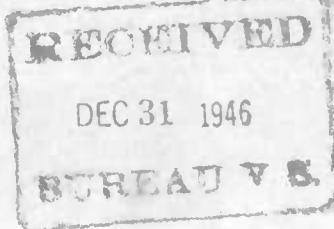
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 12-25-46Where did injury occur? Damascus County Montgomery State Md.Injured at home, farm, industry, public place (where?) Trap shootMeans of injury Shot gun Injured at work? No23. SIGNATURE Frank J. Brumhart M.D. M. D. or otherAddress Gaithersburg, Md. Date signed 12-26-46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82-6

12212

CERTIFICATE OF DEATH

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County... Montgomery

City or town... Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 5 months 19 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution?... 5 months 19 days

3. (a) FULL NAME

Burke, Mrs. Mary Eva

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife... Thomas J. Burke

7. Birth date of deceased (mo., day, yr.) Dec. 9 - 1892

6. (c) If alive, give age... years

8. AGE: Years Months Days If less than one day
54 0 7 - hrs. - min.9. Birthplace... Washington, D.C.
(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business... Same

12. Name... Edward Fleishall

13. Birthplace Washington, D.C.

14. Maiden name... Sarah Walemeyer

15. Birthplace Washington, D.C.

16. Informant... Records - Washington Sanitarium and Hospital

Address... 700 Carroll Avenue, Takoma Park, Maryland

17. Burial Date thereof... Dec. 1946
(Burial, cremation or removal, when)

(month) (day) (year)

Cemetery or crematory... Mt. Olivet

Location... Bethesda, D.C.

18. Funeral director... Collins Funeral Home

Address... 3821-14th Street, N.W.

19. Deceased Date rec'd by registrar... Dec. 17 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... Montgomery

City or town... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No... 105 Hilltop Road

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

Yes - Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH... December 16 1946 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-4-1942 to 12-16-1946

and that I last saw her alive on 12-16-1946

Immediate cause of death...

Cerebral infarcts

DURATION

3 yrs.

Due to... cerebral arteriosclerosis

10 yrs.

Due to... generalized arteriosclerosis

10 yrs.

Other conditions... chronic passive congestive lungs

3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of...

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Cause of Injury

Injured at work?

23. SIGNATURE...

M. D. or other

Address... 8005 Woodbury Drive

Silver Spring, Md.

Date signed 1/1/1946

RECEIVED

DEC 21 1946

BUREAU OF INVESTIGATION

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

12213

CERTIFICATE OF DEATH

Reg. Dist. No. 2140

W
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County... Montgomery
 City or town... Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days
 Hospital, Institution, or street address where death occurred:
 215 Franklin Ave

How long in hospital or institution?

3. (a) FULL NAME
 Margaret Busch
 4. Sex F 5. Color or race W Widowed

6. (a) Single, married, widowed, or divorced
 Henry Bernard Busch

8. (c) If alive, give age years
 21 May 1864

7. Birth date of deceased (mo., day, yr.)
 8. AGE: Years 82 Months Days It less than one day
 hrs. min.

9. Birthplace Baltimore, Md
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Patrick Bennett
 13. Birthplace Ireland

MOTHER 14. Maiden name unknown
 15. Birthplace unknown

16. Informant Mrs. F. E. Rindge
 Address 215 Franklin Ave, Silver Spring, Md

Burial 17. Date thereof Dec. 28, 1946.
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer
 Location Baltimore, Maryland

18. Funeral director Francis J. Collins
 Address 3821-14th St. N.W. Wash. D.C.

19. Dec 25 1946 Josephine M. Schaeffer
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State... Maryland County... Harford
 City or town... Harbor de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 407 S. Union Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Dec 1946 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 75 Dec 1946 to 25 Dec 1946 and that I last saw her alive on 19.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE William D. And M.D.

M. D. or other

Address 9006 Colvin Rd Date signed 25 Dec 46

Silver Spring Md



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467 X

12214

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 7 days

Hospital, institution, or street address where death occurred:

USNH, Bethesda, Md.

How long in hospital or institution? 3 mos. 7 days

3. (a) FULL NAME

CAGEY, Vaughn Franklin

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6. (b) Name of husband or wife... Edythe Gagey

6. (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) August 12, 1901

8. AGE: Years	Months	Days	If less than one day
45	3	26	hrs. min.

9. Birthplace... Pennsylvania
(Town, county, and state)

10. Usual occupation... Guard & Special Police

11. Industry or business Civil Service

MOTHER FATHER	12. Name...
	Charlie Gagey

13. Birthplace	Penn.
----------------	-------

14. Maiden name	Laura Ruse
-----------------	------------

15. Birthplace	Penn.
----------------	-------

16. Informant... Mrs. Edythe Gagey

Address 705 4th Street, NW, Washington, D. C.

17. burial Date thereof... 12-10-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Arlington National

Location... Arlington, Va.

18. Funeral director W.W. Chambers

Address 517 11th St. SE, Washington, D. C.

19. 12-8 1946 Mary Charlotte Smith

(Date rec'd by registrar) (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...

City or town... Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 705 4th Street, NW
(If rural, give LOCATION)

2.(a) If veteran, name war... World War I

3. (b) Social Security Number

100 05 3033

MEDICAL CERTIFICATION

20. DATE OF DEATH... 8 Dec. 19 46 at 5:58 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 July 1946 to 8 Dec. 1946.

and that I last saw h. i.m. alive on 8 Dec. 1946.

Immediate cause of death... Ascension Pancreas

Due to... /yr

Due to... /yr

Other conditions... Jaundice

Cause of death... Ascension Pancreas
(Include pregnancy within 3 months of death)

Major findings of operations... Date of op.

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

Signature... Frank S. ASHBURN, Condr. (MC) USN

M. D. or other

Address... USNH Bethesda, Md. Date signed... 12-8-46

RECEIVED

DEC 12 1946

BUREAU OF INVESTIGATION

1-25-

2-2160 - 1 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-20

12215

CERTIFICATE OF DEATH

Reg. Dist. No. 7140

1. PLACE OF DEATH:

County.....

Montgomery

City or town..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death..... 20 yrs

Hospital, institution, or street address where death occurred:

15 Prospect St

How long in hospital or institution?

3. (a) FULL NAME

Joseph B. Chamberlain

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male white married

6.(b) Name of husband or wife

Anna Chamberlain

6.(c) If alive, give age..... 70 years

7. Birth date of deceased (mo., day, yr.)

May 4 1863

8. AGE:

Years

Months

Days

If less than one day

83

8

hrs.

min.

9. Birthplace

Centreville N.H.

(Town, county, and state)

10. Usual occupation

Novelty Manufacture

11. Industry or business

Jernica Chamberlain

12. Name

Jernica Chamberlain

MOTHER FATHER

13. Birthplace

N.H.

14. Maiden name

Grace Burleigh

15. Birthplace

N.H.

16. Informant

Anna Chamberlain

Address

15 Prospect St. Kensington Md

Cremation

Date thereof 10/4/47

(month) (day) (year)

(Burial, cremation, or removal) Which?

Cemetery or crematory

Lee's Crematorium

Location

Wash. D.C.

18. Funeral director

J.W. Lee's Sons Co

Address

300-4-57 N.E. Wash. D.C.

19. Name

James F. 19-47

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington (If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Prospect St (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1947 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dep Med Exam 19 10 19

and that I last saw h alive on case 19

Immediate cause of death

Chloroform poisoning

Due to

Suicide

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... suicide Date of 1-4-47

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dep Med Examiner M.D. or other

Address Martha L. Schaffner 1-4-47

JAN 8 1947

BUREAU V

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

12216

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County.....

City or town.....

Brentwood, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hosp

How long in hospital or institution?

3. (a) FULL NAME

Clark William

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W

W

6.(b) Name of husband or wife.....

Mary Alice Clark

7. Birth date of deceased (mo., day, yr.)

Dec. 13, 1888

6.(c) If alive, give age..... years

8. AGE:

Years
58

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Bellvue, Texas

(Town, county, and state)

10. Usual occupation.....

Patient Examiner

11. Industry or business.....

U.S. Govt,

12. Name.....

A. G. Clark

13. Birthplace.....

Ill.

14. Maiden name.....

Minerva Green

15. Birthplace.....

Ill.

16. Informant.....

Mary Alice Clark

Address

2948 Euston St. 91. 91

17. (Burial, cremation, or removal, Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Rock Creek Cem

Location.....

Nash - DC

18. Funeral director.....

The S. H. King Co.

Address

2901 14th St. N.W.

19. (Date rec'd by registrar)

12/5 1946

Wm E Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Wash.

County..... D.C.

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... 2033 O St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

5/December/1946

at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 6 1946 to Dec. 5 1946

and that I last saw him alive on Dec. 5 1946

Immediate cause of death.....

Myocardial Infarction

DURATION

3 days

Due to..... coronary artery disease

4-5 years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

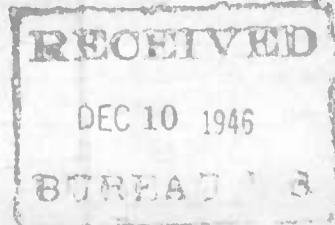
Injured at work?

Charles P. H. Halleck, M.D.

M. D. or other

Address..... 1801 Euston St. N.W.

Date signed..... 12/5/46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

12217

CERTIFICATE OF DEATH

Reg. Dist. No. 2130

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Flat Ave -

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John W. Clouser

7. Birth date of deceased (mo., day, yr.)

October 4-1897

6. (c) If alive, give age years

8. AGE:

Years Months Days It less than one day
49 2 7 hrs. min.

9. Birthplace

Montgomery County - Maryland

(town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Own home

12. Name

Samuel Lowe

13. Birthplace

Montgomery Co. Maryland

14. Maiden name

Aurie Margaret Bellair

15. Birthplace

Montgomery Co. Maryland

16. Informant

John W. Clouser - husband

Address

Flat Ave - Rockville - Md

17. Burial

Date thereof Dec. 14/46

(month) (day) (year)

Cemetery or crematory

Forest Oak Cemetery

Location

Gaithersburg - Maryland

18. Funeral director

John Peabody Funeral Home

Address

Rockville - Maryland

19. Date rec'd by registrar

12-11 1946

19

Date registered

46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

City or town

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1946 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 25 1946 to Dec. 11 1946

and that I last saw her alive on Dec. 10 1946

Immediate cause of death

Cerebral hemorrhage

Due to arteriosclerosis

Hypertension

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

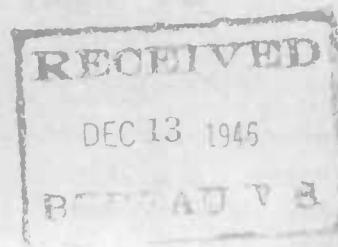
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. G. Smith, M.D.

M. D. or other

Address Rockville, Md. Date signed 12/11/46



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and clearly. Correct age is especially important. Physicians: please write the causes of death clearly and definitely.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-ai

12218

CERTIFICATE OF DEATH

Reg. Dist. No. 7160

1. PLACE OF DEATH

County Montgomery
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Dec 17, 1946

Hospital, institution, or street address where death occurred:

Suburban Hospital 8600 Old Georgetown Rd.

How long in hospital or institution? Since Dec 13, 1946 - Bethesda, Md.

3. (a) FULL NAME

Mrs Grace B. Cooley

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

WWMAXWELL S. Cooley

7. Birth date of deceased (mo., day, yr.)

MAR. 25, 1874

6. (c) If alive, give age

years

8. AGE:

72

Years

8

Months

22

Days

If less than one day

hrs. min.

9. Birthplace

Elmira, New York

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Geo. W. Bogart

12. Name

Staten Island - New York

13. Birthplace

Eleanor T. Colgan

14. Maiden name

Ireland

15. Birthplace

Capt Geo. W. Walker

16. Informant

Chevy Chase, Maryland

Address

Shipment

(Burial, cremation, or removal. Which?)

Date thereof

12/19/46

Month (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date record by registrar)

12/17

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2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186A

12219

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County.....Montgomery

City or town.....Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Nov. 6, 1946

Hospital, institution, or street address where death occurred:

Suburban Hosp. - 8600 Old Georgetown Rd.

How long in hospital or institution? Since Nov. 6, 1946, Bethesda

3. (a) FULL NAME

LOUISE K. DAVIS

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White

6. (b) Name of husband or wife John P Davis (Dec.)

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1876

8. AGE: Years Months Days If less than one day
70 2 12 hrs. min.9. Birthplace Washington, N. Carolina
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Richard Koska

13. Birthplace ?

14. Maiden name Regina Salvi

15. Birthplace ?

16. Informant Hospital Records

Address

17. Burial Date thereof Dec. 6/46
(Burial, cremation, or removal. Which?)

Cemetery or crematory Loudon Cemetery

Location Baltimore, Md.

18. Funeral director J. H. Alines Co.

Address 2901-14th St., N.W. D.C.

19. 12/4 1946 Dr. E. Jacobs
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6000 New Hampshire Ave., N.W.
(If rural, give LOCATION)

If veteran, name war

Md.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Dec 1946

21. I CERTIFY that death occurred on the date above stated; that attended deceased from 10 Nov. 1946, to 4 Dec. 1946

and that I last saw her alive on 4 Dec. 1946

Immediate cause of death Accidental fall, ~~overturn~~

Gouty hemorrhage acute, recurrent, acute anemia

Due to Gastric ulcer, two, subacute

Pulmonary thrombosis st. 1 da.

Termination

Postural nec. st. Femur 28 da

Cerebral vascular accident

Renal disease with hypertension

Major findings of operations Cordotomy st. Femur Date of op. 13 Nov 46

Autopsy results given above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Accident Date of November 6, 1946

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Accidental fall Injured at work?

23. SIGNATURE P. H. Kilpatrick M.D.

M. D. or other

Address 5522 Western Ave., N.W. Date signed 4 Dec 46



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

CERTIFICATE OF DEATH

Reg. Dist. No.

12220

2230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County..... Montgomery
City or town..... 805 Maple Ave., Takoma Pk. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 year

Hospital, institution, or street address where death occurred:

Jolliffe Nursing Home

How long in hospital or institution?..... 1 year

3. (a) FULL NAME

Mary Florence DeFontes

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

white

widowed

6.(b) Name of husband or wife..... Salatore Joseph DeFontes

7. Birth date of deceased (mo., day, yr.)

March 17, 1875

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace..... Baltimore, Md.

(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... Henry Weil

13. Birthplace..... Maryland

MOTHER

14. Maiden name..... Mary A. Blach

15. Birthplace..... Baltimore, Maryland

16. Informant..... Frances A. DeFontes

Address..... 832 Jefferson St., N.W.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 12 - 21 - 46

(month) (day) (year)

Cemetery or crematory..... Ft. Lincoln Cemetery

Location..... Maryland

18. Funeral director..... The S. W. King Company

Address..... 2901 - 14th

Dec. 19, 1946

(Date rec'd by registrar)

J. H. M. D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Montgomery

City or town..... Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)Street No..... 423 Turner Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 18, 1946, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19, 26, to Dec 18, 1946,

and that I last saw her alive on Dec 18, 1946.

Immediate cause of death.....

Cerebral hemorrhage

DURATION

2 days

Due to..... Generalized arteriosclerosis

and hypertension

10 years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Richard V. Mattingly, M.D.

M.D. or other

Address..... 4707 Corry Ave. N.W. Wash. D.C.

Date signed..... Dec 18, 1946.

RECEIVED

DEC 21 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

CERTIFICATE OF DEATH

12221

216

Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 8:30 P.M. 12-6-46Hospital, institution, or street address where death occurred: Suburban Hosp
8600 Old Georgetown Rd - Bethesda, MDHow long in hospital or institution? Since 8:30 P.M. 12-6-46

3. (a) FULL NAME

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced6. (b) Name of husband or wife Kathleen DeLung 6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) FEB. 28 — 18708. AGE: Years 76 yrs Months Days If less than one day hrs. min. 9. Birthplace Roanoke Virginia (Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name Franklin DeLung13. Birthplace Virginia14. Maiden name Mary Burnette15. Birthplace Virginia16. Informant Mrs. A. L. WallsAddress 4618 Wisconsin Avenue, Washington, D.C.17. Burial Date thereof 12-9-46 (month) (day) (year)

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory

Location Oak Hill Cemetery18. Funeral director H. H. Chambers CoAddress 3072 M ST Washington, DC19. 12/7 1946 (Date rec'd by registrar)

9 P.M. 3 floors

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County Washington, D.C.City or town Washington, D.C. (If outside city or town limits, write RURAL and give nearest town)Street No. 4618 Wisconsin Avenue, Washington, D.C. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 194621. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19, 46 to 12-7-46 and that I last saw h. alive on 12-7- 1946.

Immediate cause of death

Myocarditis
congestive heart failure
Due to
generalized
atherosclerosis

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE P.P. Andrews M.D. M. D. or otherAddress 430 Fessenden St. N.W. Date signed 12-7-46

RECEIVED

DEC 10 1946

BIRMINGHAM

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

CERTIFICATE OF DEATH

Reg. Dist. No. 2230

12222
2230

The correct age
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly.
 is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Montgomery, Md.
 City or town: Washington, D.C. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred: Washington General Hospital

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Effie E. Deerman

4. Sex: Female | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Widower

8. (b) Name of husband or wife: Mr. Clayton Deerman

deceased

6. (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 16, 1889

8. AGE: Years: 57 Months: 3 Days: 14 If less than one day: hrs: min:

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: George W. Holloway

MOTHER FATHER: 12. Name: George W. Holloway

13. Birthplace: Baltimore, Md.

14. Maiden name: Effie E. Fair

15. Birthplace: Frederick, Md.

16. Informant: Washington D.C. Records

Address: 1000 L St. N.W.

17. Removal Date thereof: 1/31/46 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory: Washington D.C.

Location: The 2nd News Co.

18. Funeral director: 2901-14th St. N.W. Wash. D.C.

Address: 2901-14th St. N.W. Wash. D.C.

19. Place: 31 1946 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No: 408 Aspen St. D.C. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30, 1946, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19. 31, to Dec. 30, 1946, and that I last saw her alive on Dec. 30, 1946.

Immediate cause of death:

Hypertension, Cerebral Arteriosclerosis, Kidneys, 24 hrs. duration

Due to: Heart, respiratory, hypertension & long illness & atrophy, arthritis

Due to:

Other conditions: Hypertension for 15 yrs, arthritis, mitral regurgitation, presumption of coronary artery disease (Include pregnancy within 3 months of death)

Major findings or operations:

Date of op.: as above.

Autopsy results: as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

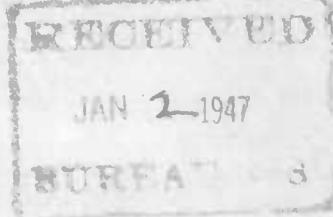
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Wm. A. Thompson, M.D. M. D. or other

Address: 112 Carroll St. NW Date signed: Jan 20 1946



1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12223

CERTIFICATE OF DEATH

216 1

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

26 days

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?.....

26 days

3. (a) FULL NAME

DENNEHY, Margaret Agnes

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

W-US

single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

27 June 1914

8. AGE:

Years

Months

Days

If less than one day

32

5

14

hrs.

min.

9. Birthplace..... Mass.

(Town, county, and state)

10. Usual occupation..... Navy

11. Industry or business

FATHER 12. Name..... John Dennehy

13. Birthplace..... Ireland dec.

MOTHER 14. Maiden name..... Ellen Dennehy

15. Birthplace..... Ireland

16. Informant Mo: Mrs. Ellen Dennehy

Address 73 Fairfax St., Sommerville, Mass.

17. burial

(Burial, cremation, or removal. Which?)

Date thereof..... 12-12-46

(month) (day) (year)

Cemetery or crematory..... Oak Grove

Location..... Medford, Mass.

18. Funeral director..... W. W. CHAMBERS Ed.

Address 1400 Chapin St., N. W. Wash., D.C.

12-12 46 Mary Charlotte Smith

19. (Date rec'd by registrar) 19.....

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Mass.

County.....

City or town..... Sommerville

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 73 Fairfax St.

(If rural, give LOCATION)

2.(a) If veteran, name war..... War

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 11

1946 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Extern care

and that I last saw h... alive on

Immediate cause of death

1st 2nd & 3rd degree burns of about 80% of body

Due to..... Suicide

DURATION

12 hrs.

Due to.....

Other conditions..... Mental Case

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Suicide Date of 12-11-46

Where did injury occur?..... Bethesda County Md. (State)

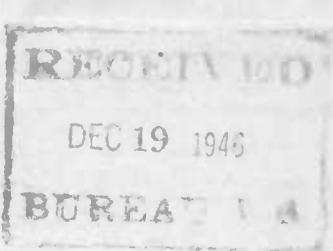
Injured at home, farm, industry, public place (where?)..... U.S. Naval Hospital

Means of Injury..... Burns Injured at work?..... No

23. SIGNATURE

Frank J. Buschard M.D. M. D. or other

Address..... 1000 Chapin St., N.W. Wash., D.C. Date signed 12-11-46



2-25

2-2160 - 4-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12224

CERTIFICATE OF DEATH

Reg. Dist. No. 283

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County

Montgomery Park

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 1/2 hrs.

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospt

How long in hospital or institution? 18 1/2 hrs.

3. (a) FULL NAME

Unnamed Baby Eiker #1

4. Sex

Male white

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 26, 1946

6. (c) If alive, give age — years

8. AGE:

Years Months Days If less than one day
18 hrs. 30 min.

9. Birthplace

Takoma Park, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name David Carlton Eiker

13. Birthplace Washington, D.C.

14. Maiden name Margaret White Blick

15. Birthplace Washington, D.C.

16. Informant Washington Sanitarium Records

Address Takoma Park, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 28, 1946
(month) (day) (year)

Cemetery or crematory Mt. Wash Mem Park Cemetery

Location Hyattsville, Md.

18. Funeral director J. Arthur Wactus

Address 254 Carroll St. 2nd Flr. D.C.

19. Rec'd by 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town Glen Echo

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Wellesley Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27-1946 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-26-1946 to 12-27-1946 and that I last saw h. s. alive on 12-27-1946

Immediate cause of death

Prematurity -6 mos gestation

DURATION

Due to twin pregnancy

Due to mother had high temp on day of delivery - cause?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

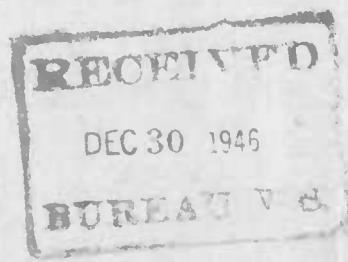
Means of injury

Injured at work

23. SIGNATURE Emma Hughes M.D.

M. D. or other

Address Takoma Park, Md. Date signed 12-27-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

12225

CERTIFICATE OF DEATH

Reg. Dist. No.

2230

1. PLACE OF DEATH:

County

Montgomery

City or town

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 hrs

Hospital, Institution, or street address where death occurred:

Washington Sanitarium + Hospital

How long in hospital or institution?..... 2 hrs

3. (a) FULL NAME

Unname Baby Eiker

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male w Baby

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 12-26-46 5th p.m.8. AGE: Years Months Days If less than one day
2 hrs. min.9. Birthplace Washington Sanitarium + Hosp
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER 12. Name David Carlton Eiker

MOTHER 13. Birthplace Wash. D.C.

14. Maiden name Marguerite Blatt

15. Birthplace Wash. D.C.

16. Informant Record on Pt's chart

Address Washington Sanitarium - Hosp

17. Burial Date thereof 12-27-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Geo Wash Mem Park

Location Biggs Rd.

18. Funeral director Arthur Walter

Address 26-4 Carroll St. Mt. D.C.

19. 12-27-46 19.....

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Glenn Echo, Md County Montgomery

City or town Glenn Echo (If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Wellesley Ave (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26-1946 at 7⁰⁰ p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-26-1946, to 12-26-1946

and that I last saw h. alive on 12-6-1946

Immediate cause of death

Prematurity - 6 mo. gestation
wt - 1 lb. 7¹/₂ oz

Due to Twin pregnancy

Due to Mother had high temp
before delivery - cause?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emma Hughes M.D.

M. D. or other

Address Takoma Park, Md. Date signed 12-26-46

RECEIVED

DEC 28 1946

BUREAU OF INVESTIGATION

1-38

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 117-B

CERTIFICATE OF DEATH

12226

Reg. Dist. No.

2161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

25 days

How long in above place of death?

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D.C. Couoly

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1939 Calvert St., NW

(If rural, give LOCATION)

2.(a) If veteran, name war..... World War II

3. (a) FULL NAME

ETTER, Frank Jackson

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife..... Hazel E. Etter

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1915

8. AGE:	Year	Month	Date	If less than one day
	31	2	26	hrs. min.

9. Birthplace..... Virginia

(Town, county, and state)

10. Usual occupation..... Painter

11. Industry or business..... Eberley's Washington, D.C.

12. Name..... James C. Etter

13. Birthplace..... Virginia

14. Maiden name..... Mary R. Hash

15. Birthplace..... Virginia

16. Informant..... Hazel E. Etter, wife

Address..... 1939 Calvert St., NW, Washington, D.C.

burial

Date thereof..... 12-7-46

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Evergreen Cemetery

Location..... Roanoke, Virginia

18. Funeral director..... W.W. Chambers

Address..... 1490 Chapin St., NW, Washington, DC

19. Date rec'd by registrar..... 7 Dec 1946

(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 7 December 1946, at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12 Nov. 1946, to 7 Dec. 1946,

and that I last saw him alive on 7 Dec. 1946.

Immediate cause of death..... Hematoporphyrinia

DURATION

3 wks

Due to..... unknown

Due to.....

Other conditions..... healed & active duodenal ulcer

Bronchopneumonia

(Include pregnancy within 3 months of death)

Major findings of operations..... negative

Date of op.

Autopsy results..... confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

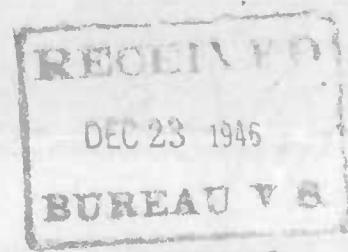
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... H. R. C. CHALMERS, Lt. Cdr. (MC) USN

M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 12-7-46



2-25

2-2160- 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

12569

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 13 days

Hospital, Institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 8 months, 13 days

3. (a) FULL NAME

FAIRFIELD, Arthur Philip Vice Admiral USN Ret. Act.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male W-US Married

B.(b) Name of husband or wife..... Nancy Fairfield

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1877 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
69 1 15 hrs. min.

9. Birthplace..... Maine (Town, county, and state)

10. Usual occupation..... Navy

11. Industry or business

12. Name..... R. A. Abler dec.

13. Birthplace..... Maine

14. Maiden name..... Frances Patton dec.

15. Birthplace..... Maine

16. Informant..... Wife: Nancy Fairfield

Address 2400 16th St. N.W. Washington, D.C.

17. Burial..... Date thereof..... 12-17-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Virginia

18. Funeral director..... W.W. CHAMBERS C.R.D.

Address 1400 Chapin St. N.W.

19. 12-15-46 19..... (Date rec'd by registrar)

Mary Charlotte Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C.

County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 2400 16th Street, N. W.

(If rural, give LOCATION)

2.(a) Is veteran, name war..... Navy

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 14 December 1946, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 April 1946, to 14 Dec. 1946,

and that I last saw him alive on 14 Dec. 1946.

Immediate cause of death.....

Myocardial Infarction

Due to..... Coronary Artery Thrombosis

Due to.....

Other conditions..... Hypertension, azotemia

and congestive heart failure

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results..... not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... No Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... R.C. PARKER CDR, M.C., U.S.N.

M. D. or other

US NH Bethesda, Md.

Date signed..... 12-15-46

RECEIVED

DEC 30 1946

BUREAU V.S.

2-25

2-2160

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12227

CERTIFICATE OF DEATH

Reg. Dist. No.

6181

1. PLACE OF DEATH:

County

Montgomery
Rural Gaithersburg MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife

Albert J. Frink

7. Birth date of deceased (mo., day, yr.) Dec 2 1885

6.(c) If alive, give age 88 years

8. AGE: Years Months Days If less than one day

61 0 2 hrs. min.

9. Birthplace (Town, county, and state)

Middleton MD

10. Usual occupation

House Wife

11. Industry or business

Home

12. Name

Hannah Reiley

MOTHER FATHER

13. Birthplace

Middleton MD

14. Maiden name

Salome Marcus

15. Birthplace

Middleton MD

16. Informant

Albert J. Frink

Address

Gaithersburg MD

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec 6 1946

(month) (day) (year)

Cemetery or crematory

St Lukes Redland

Location

Montgomery CO MD

18. Funeral director

W. W. Barber

Address

Towsonville MD

19. Date rec'd by registrar

12/6/46

19. Registrar

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

12 MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/1946 1946 at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1946 to Dec 3 1946

and that I last saw her alive on 12/1/46 1946

Immediate cause of death Acute Cardiac

Hypertension

DURATION 3 days

Due to Chronic Myocarditis 6 mos

Due to —

Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE M. D. or other

Address Sandy Spring Md Date signed 12/5/46



2-2180-1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33)

CERTIFICATE OF DEATH

Reg. Dist. No. 12228780

1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

8 hours

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?.....

8 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Montgomery

City or town.....

Darnestown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

Mr. Julian Griffith

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

May 20, 1873

6.(c) If alive, give age years

8. AGE:

73

Years

Months

Days

If less than one day

7

7

hrs.

min.

9. Birthplace..... Darnestown, Montgomery, Maryland

(Town, county, and state)

10. Usual occupation.....

Retired Government Employee

11. Industry or business

MOTHER FATHER

12. Name..... Julian Griffith

13. Birthplace..... Montgomery Co. Maryland

14. Maiden name..... Mary V. Harper

15. Birthplace..... Montgomery Co. Maryland

16. Informant..... Mrs. Clyde Griffith

Address.....

Gaithersburg, Md. R.F.D.

17. Burial.....

(Burial, cremation, or removal, Which?)

Date thereof..... 12-29-46

(month) (day) (year)

Cemetery or crematory.....

Darnestown Cemetery

Location.....

Darnestown, Md.

16. Funeral director.....

E C Gartner

Address.....

Gaithersburg, Md.

19. File no.

19-46

Abundant

Signature

Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Montgomery

City or town.....

Darnestown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

December 27, 1946, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on

Dec. 26,

1946, to

and that I last saw him alive on Dec. 26, 1946.

1946.

Immediate cause of death was Bronchitis -

Pneumonia (Secondary to

Influenza).

Due to.....

Due to.....

Other conditions Marked depression

of respiratory center

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

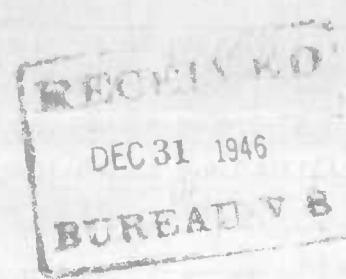
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Dawsonville Md. Date signed Dec. 28, 1946



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

12229

Reg. Dist. No. 2723

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

801 Greenwood Ave.

How long in hospital or institution?

3. (a) FULL NAME

Grace Moore Guilford

4. Sex Fe 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife James W. Guilford

7. Birth date of deceased (mo., day, yr.) June 1, 1868

8. AGE: Years 78 Months 6 Days 4 If less than one day hrs. min.

9. Birthplace Hastings, Barry County, Michigan

(Town, county and state)

10. Usual occupation Secretary

11. Industry or business

MOTHER FATHER 12. Name Levi G. Moore

13. Birthplace Walled Lake, Michigan

14. Maiden name Alice Bands Moore

15. Birthplace Asa, Michigan

16. Informant Daughter, Maudie Guilford Wood

Address 801 Greenwood Ave, Takoma Park, MD

17. Burial Date thereof Dec. 7, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory Mt. Hope Cemetery

Location Lansing, Mich.

18. Funeral director Robert D. Alderson

Address 25 Carroll St., Johns Hopkins, Md.

19. Rec'd by (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Montgomery

City or town..... Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 801 Greenwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5/46 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1946 to December 1946

and that I last saw her alive on December 12, 1946

Immediate cause of death Bronchitis, pneumonia

Duration 5 days

Due to.....

Due to.....

Other conditions Hypertension

Cardio vascular renal disease

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

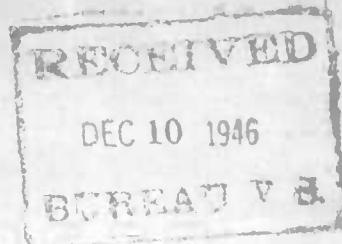
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Benjamin, M.D.

M. D. or other

Address Bethesda, Md. Date signed 12/5/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12230

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. *Long correct age*

1. PLACE OF DEATH: Montgomery
 County.....
 City or town..... Bethesda, Md. (rural)
 (If outside city or town limits, write RURAL and give nearest town) 38 days
 How long in above place of death?.....
 Hospital, Institution, or street address where death occurred: US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?..... 38 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... D.C. County..... Washington
 City or town..... (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9 Leeward Green
 (If rural, give LOCATION) World War I
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 HADDOCK, John Alfred,

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife..... Mrs. Mable Haddock

7. Birth date of deceased (mo. day, yr.) 11 June 1898
 6. (c) If alive, give age..... years

8. AGE: Years 48 Months 6 Days 9 If less than one day hrs. min.

9. Birthplace..... Pa. (Town, county, and state)

10. Usual occupation..... Crayman, Navy Dept.

11. Industry or business

12. Name..... Mr. John Haddock

13. Birthplace..... Pa.

14. Maiden name..... Wade Cunningham

15. Birthplace..... Pa. dec.

16. Informant..... wife: Mrs. John Haddock

Address 9 Leeward Green, Wash., D.C.

17. burial Date thereof 12-23-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Va.

18. Funeral director..... W.W. Chambers, - K. Burns

Address 1400 Chapin St., N.W. Wash. D.C.

19. 12-20 46 Mary Charlotte Smith
 (Date rec'd by registrar) 19.....

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 20 Dec. 19 46 at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Nov. 19 46 to 20 Dec. 19 46

and that I last saw him alive on 20 Dec. 19 46

Immediate cause of death..... mesenteric embolism and broncho pneumonia
 Due to..... purulent ThrombosisDue to..... aortic fib. due to
 Purulent Thrombosis due to

Other conditions..... Chronic heart disease

Cerebral embolus
 (Include pregnancy within 8 months of death) birth

Major findings of operations.....

Date of op.

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

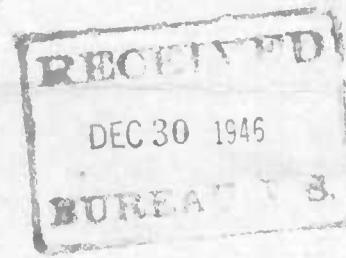
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... C. W. THOMPSON, Lt. Cdr. (MC) USNR

M. D. or other.....

Address USNH Bethesda, Md. Date signed 12-20-46



2-25

2-2160

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2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

12232140
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County MONTGOMERY

City or town SILVER SPRING

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 1/2 yrs

Hospital, institution, or street address where death occurred:

7 NORMANDY DRIVE

How long in hospital or institution?

3. (a) FULL NAME

CARRIE J. HAYDEN

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALE WHITE DIVORCED

6.(b) Name of husband or wife

CHARLES

7. Birth date of deceased (mo., day, yr.)

4 JAN. 1898

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

48

11

.....hrs.min.

9. Birthplace FEDERALBURG MARYLAND

(Town, county, and state)

10. Usual occupation

CLERK

11. Industry or business

GENERAL ELECTRIC CO.

12. Name

JOHN FUHR

13. Birthplace

MARYLAND

14. Maiden name

MARY O'DAY

15. Birthplace

MARYLAND

16. Informant

HAROLD R. BECKLEY

Address

7 NORMANDY DRIVE, 38, MD.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12-14-46

(month) (day) (year)

Cemetery or crematory

FORT LINCOLN

Location

Prince George's Co. Md

18. Funeral director

NW Chambers Inc.

Address

1400 Chapin St. N.W.

19. Dec 12 1946 Josephine W. Chapman

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

County MONTGOMERY State MONTGOMERY (For newborn infants give residence of mother)

City or town SILVER SPRING County MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7 Normandy Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

12 DECEMBER 1946 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 MAY 1946 to 12 DEC. 1946

and that I last saw h.e.r. alive on 11 DEC. 1946

Immediate cause of death VENTRICULAR FIBRILLATION, CONGESTIVE

HEART FAILURE

Due to RHEUMATIC MYO- AND

ENDOCARDITIS

Due to RHEUMATIC FEVER

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

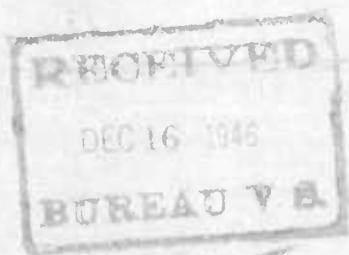
Injured at work?

23. SIGNATURE

Marshall Leveillier Jr. M.D. or other

Address 8448 GEORGIA AVE Date signed 12 DEC. 46

SILVER SPRING, MD.



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2020

12232

CERTIFICATE OF DEATH

Reg. Dist. No. 2130

1. PLACE OF DEATH:

County

Montgomery
Rural - Tow Rockville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 years

Hospital, institution, or street address where death occurred:

R.F.D. Rockville

How long in hospital or institution?

3. (a) FULL NAME

Edward Ariel Howell

4. Sex

Male

5. Color or race

White

8.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Virginia U. Howell

7. Birth date of deceased (mo., day, yr.)

October 7-1872

6.(c) If alive, give age 69 years

8. AGE:

Years Months Days If less than one day

74 2 2 hrs. min.

9. Birthplace

Fairfield - Iowa

(Town, county, and state)

10. Usual occupation

Retired - U.S. Postal Employee

11. Industry or business

Virginia Howell

MOTHER

12. Name

Fairfield - Iowa

13. Birthplace

Katherine Mount

14. Maiden name

Fairfield - Iowa

15. Birthplace

Mrs. Virginia Howell

16. Informant

R.F.D. Rockville - Md

17. Burial

Date thereof Dec 17-146

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Berwyn - Maryland

18. Funeral director Wm. Scrubn Temple

Address Rockville - Maryland

Booker T. Washington

Registrars

19. 12-10-1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural - nw - Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. Rockville

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

577-30-1476

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1946 at 3:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1945 to Dec 9 1946

end that I last saw him alive on December 8 1946

Immediate cause of death congestive

heart failure

DURATION 2 days

Due to Chronic valvular

heart disease

general

years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

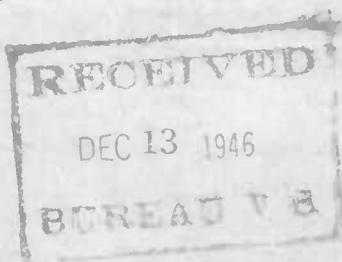
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE G. J. Hartley M.D.

M. D. or other

Address Rockville, Md. Date signed 12/10/146



1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

12233

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

20 Minutes

3. (a) FULL NAME

O Beulah Carol Hunter

4. Sex

Female White Married

Color or race

6. (a) Single, married, widowed, or divorced

5. (b) Name of husband or wife

Richard

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age

years

December 28 1922

8. AGE:

58 Years 10 Months 20 Days

It less than one day

hrs. min.

9. Birthplace

Towson, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

William McCormick

12. Name

Richard D. Hunter

13. Birthplace

Towson

14. Maiden name

Victoria Cole

15. Birthplace

Towson

16. Informant

Richard D. Hunter

Address

Cabin John Branch

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 29, 1944

(month) (day) (year)

Cemetery or crematory

Potomac Church Cemetery

Location

Maryland

18. Funeral director

Wm Reuben Humphrey

Address

Bethesda, Maryland

19. 17/28 1946

(Date rec'd by registrar)

7th E Jakes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Cabin John

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3rd St

(If rural, give LOCATION)

No

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

12/26

1946 at 10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1938 to June 25 1946

and that I last saw her alive on June 25 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

1 hr

Due to

Hypertension

10 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Lee D. Gossamer

M. D. or other

Address

Asst Physician Dr

Date signed

RECEIVED

JAN 4 1947

BUREAU OF ECONOMIC INFORMATION

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12580

CERTIFICATE OF DEATH

Reg. Distr. No. 216

1. PLACE OF DEATH:
 County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 hours
 Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 13 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4803 Hampton Lane
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
IVEY, Ralf Julian

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife Mrs. Iva Ivey

7. Birth date of deceased (mo., day, yr.) 7-29-92

8. AGE: Years 54 Months 4 Days 28 If less than one day
 hrs. _____ min. _____

9. Birthplace Fla.
 (Town, county, and state)

10. Usual occupation Pharm., People's Drug Store

11. Industry or business

FATHER
 12. Name Robert A. Ivey
 13. Birthplace Fla. (dec.)

MOTHER
 14. Maiden name Elizabeth Daracutt
 15. Birthplace Fla. (dec.)

16. Informant wife: Mrs. Iva Ivey
 Address 4803 Hampton Lane, Bethesda, Md.

17. removal Date thereof 12-27-46
 (Burial, cremation, or removal. Which?)
 (month) (day) (year)

Cemetery or crematory _____

Location Lake City, Fla.

18. Funeral director W. W. CHAMBERS

Address Georgetown, D. C.

19. 12-27 1946 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Dec. 1946 at 9: A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 Dec. 1946 to 27 Dec. 1946 and that I last saw him in alive on 27 Dec. 1946

Immediate cause of death Pneumonia II

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results yes no done Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Motens of Injury _____ Injured at work? _____

23. SIGNATURE J.W.S. SMITH, Comdr. (MC) USN M. D. or other _____

Address USNH Bethesda, Md. Date signed 12-7-46

RECEIVED

JAN 10 1947

BUREAU OF

2-25

2-2160 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460

CERTIFICATE OF DEATH

Reg. Dist. No. 2,60

12234

1. PLACE OF DEATH:

County. Montgomery
City or town. Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Dec. 18, 1946

Hospital, institution, or street address where death occurred: Suburban Hosp., 8600 Old Georgetown Rd

How long in hospital or institution? Since Dec. 18, Bethesda MD

3. (a) FULL NAME

Mrs Bell S. Jones

4. Sex F 5. Color or race 6. (e) Single, married, widowed, or divorced

6. (b) Name of husband Walker W. Jones (Dec.)

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1880 6. (c) If alive, give age years

8. AGE: Years Months Days II less than one day 66 10 5 hrs. min.

9. Birthplace Accomac Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Geo Thomas Scarborough

13. Birthplace Accomac, Virginia

14. Maiden name Henrietta E. Blackstone

15. Birthplace Accomac, Virginia

16. Informant Mrs Edward E. Mullin

Address 45 Fawcett St. Kensington, Md

17. Burial Date thereof 12/23/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Natl. Cem

Location Arlington, Virginia

18. Funeral director Elmer Reuben Gurney

Address 7557 Wisconsin Ave. Bethesda, Md

19. 12/23/46 9pm 5 Jubes
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. Maryland County. Montg.

City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)Street No. 45 Fawcett St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1946, at 3:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 16, 1946, to Dec. 21, 1946, and that I last saw her alive on Dec. 21, 1946.

Immediate cause of death

Carcinoma of uterus

DURATION

1 year

Due to

Due to

Due to

Other conditions Intraperitoneal hemorrhage
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?
Signature E.S. Powersfield M.D.

M. D. or other

Address Bethesda, Md Date signed 12/23/46

RECEIVED

DEC 28 1946

BURFAT & CO

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

12235

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 years

Hospital, institution, or street address where death occurred:

708 SLIGO AVE

Jolliff's Nursing Home

SILVER SPRING

How long in hospital or institution?

2 days

3. (a) FULL NAME

Annie Millington Kauffmann

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed.

6. (b) Name of husband or wife

William Peter Kauffmann

Deceased

7. Birth date of deceased (mo. day. yr.)

September 8, 1868

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

78

2

25

hrs. min.

9. Birthplace

Darby, England.

(town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

12. Name

Henry Oldrow Millington

13. Birthplace

Darby, England.

14. Maiden name

Unknown

15. Birthplace

11

16. Informant

Son: Maj. William Peter Kauffmann

Address

8404 - Ramsey Ave, Silver Spring Md.

17. Shipment + Burial Date thereof

Dec. 5, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Laurel Cemetery

Location

Port Jervis, Orange Co. N.Y.

18. Funeral director

Warren E. Pumphrey

Address

Silver Spring, Md.

19. See 4

19.46 Josephine M. Schaeffer

(Date rec'd by registrar)

Registered

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 8404 - Ramsey Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1946, at 7:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1, 1946, to December 3, 1946, and that I last saw her alive on December 3, 1946.

Immediate cause of death

Cerebral Hemorrhage

DURATION

4 days

Due to Hypertension arterial

7 years

Due to

Other conditions Fracture left femur

4 days

(Include pregnancy within 3 months of death)

Major findings or operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Acc.

Date of 11/29/46

Where did injury occur

Silver Spring

(City or town) Md.

(County)

(State)

Injured at home, farm, industry, public place (where?)

Home

Means of injury

Fall in room

Injured at work? no

23. SIGNATURE

Frank J. Bacon, M.D.

M. D. or other

Address 62-Knowles Ave, Kensington, Md.

Date signed Dec. 8, 1946

RECEIVED

DEC 6 1946

BUREAU OF

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46d

CERTIFICATE OF DEATH

12236

216 1

Reg. Dist. No.

1. PLACE OF DEATH:

Montgomery
County

Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 1 day

Hospital, institution, or street address where death occurred:

USNH, Bethesda, Md.

How long in hospital or institution? 2 mos. 1 day

3. (a) FULL NAME

KING, Guy Bryan

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife Mrs. Elizabeth King

7. Birth date of deceased (mo. day, yr.) July 15, 1896 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
50 5 4 hrs. min.9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business

12. Name Benjamin King (dec.)

13. Birthplace Maryland

14. Maiden name Rose Brown

15. Birthplace Maryland

16. Informant Mrs. Elizabeth King

Address 1904 Fairfax Rd, Annapolis, Md.

17. Burial

Date thereof 12-21-46
(month) (day) (year)

Cemetery or crematory

Location Annapolis, Md.

18. Funeral director Ben L. Slapping B.L.S.

Address 207 West St. Annapolis, Md.

19. 12-19 19 V6 Mary Charlotte Smith
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1904 Fairfax Road

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 December 19 46 at 7:15A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
18 Oct. 19 46 to 19 Dec. 19 46

and that I last saw h. in alive on 19 Dec. 19 46

Immediate cause of death

Carcinoma of Rectum

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

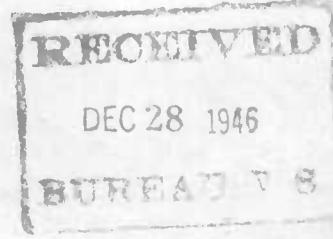
23. SIGNATURE

Paul Grant MD
VSN Hospital Bethesda Md.

M.D. or other

Date signed

12-20-46



2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 41

12237

CERTIFICATE OF DEATH

Reg. Dist. No. 2180

1. PLACE OF DEATH: Montg Co,
County..... Gaithersburg Md,
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME
Alice Arlene Kinsey

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

Granvil Kinsey

6.(b) Name of husband or wife.....

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9th 1881

8. AGE: Years	Months	Days	If less than one day
1881	65	5	29
			hrs. min.

Damascus Md,

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

House wife

11. Industry or business.....

Milton Boyer

12. Name..... Md

13. Birthplace.....

Elizabeth Purdum

14. Maiden name..... Md

15. Birthplace.....

Edwin Kinsey

Address..... Gaithersburg Md

Burial..... 12/10/46

17. (Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)

Cemetery or crematory..... Damascus Cemetery

Location..... Damascus Md,

18. Funeral director..... Ernest C Gartner

Address..... Gaithersburg Md

19. Dec 9 1946 Abuda & Cooke

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Md County..... Montg

City or town..... Gaithersburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

Dec Bth 1946 230A M

20. DATE OF DEATH..... 1946 al 1946 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 6 1946 to Dec 8 1946

and that I last saw her alive on Dec 8 1946

Immediate cause of death..... Chronic nephritis

Due to..... arteriosclerosis

Due to..... Senility

Other conditions..... Diabetes mellitus

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Head of family, M.D.

M. D. or other.....

Address..... Dawsonville, Md. Date signed..... Dec 1946

RECEIVED

DEC 12 1946

BUFFALO 7-6

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

12238

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hosp., 8600 Old Georgetown Rd
 Bethesda MD

How long in hospital or institution?

3. (a) FULL NAME

Mrs Beatrice Kokalis4. Sex Female 5. Color or race W 6.(a) Single, married, widowed, or divorced6.(b) Name Paul Kokalis7. Birth date of deceased (mo., day, yr.) Uncertain 14/Jan/1889 8. (c) If alive, give age years8. AGE: Years 57 Months 1 Days 5 It less than one day hrs. min.9. Birthplace Sparta Greece (Town, county, and state)10. Usual occupation Homemaker

11. Industry or business

12. Name Venerch MOTHER FATHER13. Birthplace Greece

14. Maiden name

15. Birthplace Greece16. Informant Charles L. L. Hally M.D.Address 1801 Eye St. N.W.17. Removal Date thereof Dec 19-1946 (month) (day) (year)

Cemetery or crematory

Location Washington D.C.18. Funeral director St. J. Charles CoAddress Washington, DC19. 12/19 1946 2pm 3 jobs (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4300 S Dakota Ave., N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1946 at 7 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Nov 1943 to 19 Dec 1946, and that I last saw him alive on 19 Dec 1946.

Immediate cause of death

CEREBRAL HEMORRHAGE

DURATION

? HoursDue to HYPERTENSIVE CARDIO-VASCULAR DISEASE

? YEARS

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results HEAD NOT DONE - ENLARGED HEART
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

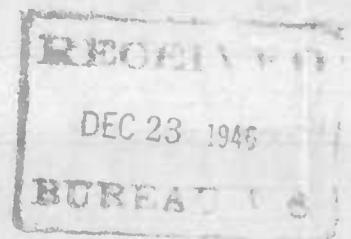
Means of injury

Injured at work?

23. SIGNATURE Charles L. Hally M.D.

M. D. or other

Address 1801 Eye St. N.W. Date signed 19 Dec 1946



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 99

CERTIFICATE OF DEATH

12239
Reg. Dist. No. 2180

1. PLACE OF DEATH:
 County Montgomery
 City or town Shady Grove, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Now long in above place of death? 5 months
 Hospital, institution, or street address where death occurred: Mrs. Gaithers Rest Home
 Now long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Bethesda, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

WILLIAM HENRY LARMAN

3. (b) Social Security Number No

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Widowed
-------------	------------------------	---

6.(b) Name of husband or wife Johanna C. Larman

7. Birth date of deceased (mo., day, yr.) June 22, 1851
 8.(c) If alive, give age years

8. AGE: Years 95	Months 7	Days 3	If less than one day hrs. min.
------------------	----------	--------	-------------------------------------

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER	12. Name John Q. Larman
	13. Birthplace Frederick Co., Maryland

MOTHER	14. Maiden name Mary J. Wakinight
	15. Birthplace Maryland

16. Informant Mrs. Christina L. Ebaugh

Address 3906 East West Highway

Burial Date thereof 12/28/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery
 Location Washington D. C.

18. Funeral director Dr. Robert Gumprecht
 Address 7557 Wis. Ave. Bethesda, Maryland

19. Dec 27 1946 Alvin G. Cooke
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1946 et 145P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27 1946 to December 25 1946

and that I last saw h. in alive on Dec. 25 1946

Immediate cause of death Toxemia resulting from gangrenous trid

DURATION 4 days
 Due to Raynaud's disease about 6 months

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE G. P. Hartley M.D. M. D. or other

Address Rockville, Md. Date signed 12/26/46

61124-40-DEPARTMENT OF STATE CHILDREN

61124-40-STATEMENT

RECEIVED

DEC 28 1946

BUREAU C-8

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

122402160
Reg. Dist. No.

1. PLACE OF DEATH:

County.....*Montgomery*City or town.....*Bethesda, Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*15 min.*

Hospital, institution, or street address where death occurred:

*Suburban Hospital*How long in hospital or institution?.....*15 min.*

3. (a) FULL NAME

Louise Sahli Louvelles

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE White MARRIED

6. (b) Name of husband or wife

SAMUEL D. Louvelles

7. Birth date of deceased (mo., day, yr.)

Oct 12 1887

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Norristown, Pa., Ohio

(Town, county, and state)

10. Usual occupation.....

HOME MAKER

11. Industry or business

MOTHER FATHER

OTTO SAHLI

13. Birthplace

Switzerland

14. Maiden name

EMMA WITSCHY

15. Birthplace

Switzerland

16. Informant.....

*Husband*Address.....*4311 Clearbrook Lane, Kensington, Md.*

17. Burial

(Burial, cremation, or removal. Where?)

Date thereof.....*12/11/46*

(month) (day) (year)

Cemetery or cremator

Grospeal Dell Cemetery

Location.....

WASHINGTON, D.C.

18. Funeral director

Josiah F. Birches Sons

Address.....

3034 - 1st St. N.W. Wash. D.C.

19. (Date rec'd by registrar)

*12/18/46**1946**9pm to Jakes*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland*County.....*Maryland*City or town.....*Kensington*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....*4311 Clearbrook Lane*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Dec 8* 1946 at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Day and Evening care 19 to 19

and that I last saw him alive on 19

Immediate cause of death.....

Cerebral hemorrhage

Due to.....

Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

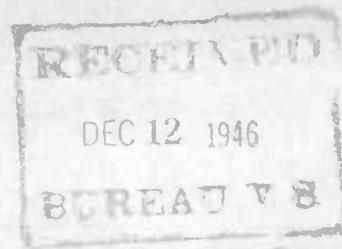
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

Frank J. Grossbach M.D.
Day and Evening care M. D. or otherAddress.....*122402160* Date signed.....*12/8/46*



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12241

CERTIFICATE OF DEATH

Reg. Dist. No. 7140

1. PLACE OF DEATH:

County.....

Montgomery
Bengtson, Md.City or town.....
(If outside city or town limits, write RURAL and give nearest town)

(If outside city or town limits, write RURAL and give nearest town)

(If outside city or town limits, write RURAL and give nearest town)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lena May Luxen

4. Sex

Female White Widower

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband

Henry Luxen

7. Birth date of deceased (mo., day, yr.)

Sept. 15th 1884

(If alive, give age)

years

8. AGE:

62 Years Months Days It less than one day

hrs. min.

9. Birthplace

Missouri

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Harry M. Danison

12. Name

Harry M. Danison

13. Birthplace

Ind.

14. Maiden name

Ida Mattingly

15. Birthplace

Mo.

16. Informant

Mr. C Ray Danison

17. Address

9632 Kensington Parkway, Montgomery, Md.

Cremated

Date thereof: Oct. 3 1946

(month) (day) (year)

18. Cemetery or crematory

Glenmary City, Missouri

Location

Cherry Chase Funeral Home

18. Funeral director

5103 31st and N.W. Wash. D.C.

Address

Date rec'd by registrar

Dec 1 1946

Josephine M. Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Bengtson, Md.

Street No.....

9632 Kensington Parkway

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 1, 1946 at 2⁰⁰ A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

December 1, 1946, to December 1, 1946,

and that I last saw her alive on December 1, 1946.

Immediate cause of death Congestive Heart

Failure

DURATION

3 months

Due to Arterio Sclerosis

15 years

Due to Rheumatic Fever

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

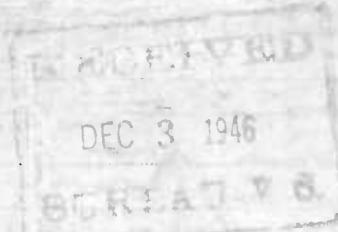
23. SIGNATURE

Robert D. Howell M.D.

M. D. or other

Address 5516 Nebraska Ave, DC Date signed 12/1/46

1-35



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

12242

CERTIFICATE OF DEATH

Reg. Dist. No. 4230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 18 days

3. (a) FULL NAME

Mack, Mr. Sidney John

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Mrs. Martina Mack

7. Birth date of deceased (mo., day, yr.)

Sept. 5, 18836.(c) If alive, give age 58 years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Lakeview, Penn.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

MOTHER FATHER

12. Name John Mack

13. Birthplace

Penn.

14. Maiden name

Penn.

15. Birthplace

Penn.

16. Informant

Washington Sanitarium and Hosp.

Address

Takoma Park, Md.

17. Burial

Date thereof

Dec. 19-1946

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Arlington National Cemetery

Location

Arlington County, Va.

18. Funeral director

S.H. HINES

Address

2901-14 1/2 St. N.W.

19. Dec. 16

19

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of ColumbiaCity or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2006 Columbia Rd. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16,

1946 at 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 29 1946 to Dec. 16 1946,and that I last saw him alive on Dec. 15 1946.

Immediate cause of death

Congestive Cardiac Failure

DURATION

TerminalDue to ArteriosclerosisDue to HypertensionOther conditions Diabetes MellitusCerebral Hemorrhage

10 yrs.

17 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert Hare MD

M. D. or other

Address Takoma Park, Md.Date signed 12/16/46

RECEIVED

DEC 19 1946

2-53A

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12243

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 1 day

Hospitel, Institution, or street addree where death occurred:

USNH, Bethesda, Md.

How long in hospitel or institution? 2 mos. 1 day

3. (a) FULL NAME

MALLOY, Francis Xavier

4. Sex _____ 5. Color or race _____ 6.(a) Single, married, widowed, or divorced

male white Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) October 27, 1894

8. AGE: Years Months Days If less than one day
52 1 16 hrs. min.8. Birthplace..... New York, New York
(Town, county, and state)

10. Usuel occupation..... unknown

11. Industry or buisness

12. Name..... Joseph Malloy

13. Birthplace..... New York

14. Maiden name..... Margaret Costello

15. Birthplace..... New York

16. Informant..... Sister: Miss Anna Malloy

Address..... 201 West 109th St., N.Y., N.Y.

17. Burial..... Date thereof..... 12-15-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Calvary Cemetery

Locetion..... New York, New York

18. Funeral director..... W.W. Chambers

Address..... 1400 Chapin St., NW, Washington, D.C.

19. 12-15 1946 Mary Charlotte Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... N.Y. County.....

City or town..... New York

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 201 West 109th St.

(If rural, give LOCATION)

2.(a) If veteren, name war..... World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 11 December 1946 at 2:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12 1946 to Dec. 11 1946 and that I last saw him alive on 14 Dec. 1946.

Immediate cause of death.....

Carcinoma Stomach

Due to.....

Due to.....

Other conditione.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causee, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Name of injury.....

Injured at work?

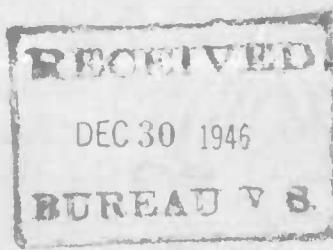
23. SIGNATURE.....

Frank S. ASHBURN, Lt.Cdr. (MC) USN

M. D. or other

Address..... USNH Bethesda, Md.

Date signed..... 12-15-46



2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12244

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County.....Montgomery

City or town.....Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....13 days

Hospital, Institution, or street address where death occurred:

USNH, Bethesda, Md.

How long in hospital or institution?.....13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....D. C.

County.....

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.....821 H St., N. E.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

MALTMAN Joseph Franklin

4. Sex.....5. Color or race.....6.(a) Single, married, widowed, or divorced

male.....white.....widowered

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....Aug. 28, 1886

6.(c) If alive, give age.....years

8. AGE: Years.....60 Months.....2 Days.....9 It less than one day.....hrs.....min.

9. Birthplace.....Delaware
(Town, county, and state)

10. Usual occupation.....unknown

11. Industry or business.....

12. Name.....Steward Maltman

13. Birthplace.....Ireland

14. Maiden name.....Emily Whiteman

15. Birthplace.....Ireland

16. Informant.....daughter: Mrs. Marie R. Schlicht

Address.....821 H St., N. E., Wash., D.C.

17. Burial.....Date thereof.....12-10-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Arlington National

Location.....Arlington, Virginia

18. Funeral director.....Timothy Hanlon Funeral Home T. J. H.

Address.....641 H St. NE, Wash., D. C.

main Charlotte Smith

12-7-1946 Mary Charlotte Smith

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....7 December 1946 at 11:50AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25, 1946, to Dec. 7, 1946, and that I last saw h. im alive on 7 Dec. 1946.

Immediate cause of death.....

Thrombosis coronary artery

Due to.....coronary artery sclerosis

Due to.....generalized arteriosclerosis
chronic nephritis + hypertension

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?)

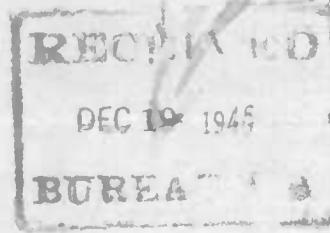
Means of Injury.....

Injured at work?

C. W. THOMPSON, Lt. Cdr. (MC) USNR

23. SIGNATURE.....M. D. or other

Address.....USNH Bethesda, Md. Date signed.....12-7-46



2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

122452140

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Montgomery
Burtonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Florence Edna McAllister

4. Sex FEMALE

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

8. (b) Name of husband or wife Edgar Ordie McAllister

7. Birth date of deceased (mo., day, yr.) May 17, 1917

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

29 6 22 hrs. min.

9. Birthplace Burtonsville, Md.

(Town, county, and state)

10. Usual occupation Radio Technician in the

11. Industry or business Airplane Factory at Riverdale, Md.

12. Name Benjamin Franklin Atley

13. Birthplace Burtonsville, Md.

14. Maiden name Mary Elizabeth Maxon

15. Birthplace Burtonsville, Md.

16. Informant Mrs. Harriet Atley

Address Burtonsville, Md.

17. Burial Date thereof Dec 13, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union

Location Burtonsville, Md.

18. Funeral director Heath Franklin

Address James. Mol

Dec 13 1946 Josephine Schaeffer

(Date rec'd by registrar) (Date signed) (M. D. or other)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Burtonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1946 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Wif Med Exam early 19. 10. 19. 19.

and that I last saw h. alive on

Immediate cause of death

Intracranial hemorrhage due to fracture of skull found dead in home

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date of 12-10-46

Where did injury occur? Burtonsville County M.D. (State)

Injured at home, farm, industry, public place (where?) home

Means of injury hammer Injured at work?

Signature Frank J. Brochart M.D.

23. SIGNATURE Dr. Frank J. Brochart M.D. M. D. or other

Address 1000 North Charles Street, Baltimore, Md. Date signed 12-10-46



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2B

12240

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

Montgomery County

Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 days

3. (a) FULL NAME

Mc MILLAN, Louise Marie

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

W-US

married

6.(b) Name of husband or wife

Milo D. McMillan

7. Birth date of deceased (mo., day, yr.)

Nov. 26, 1919

6.(c) If alive, give age years

8. AGE:

Years
27Months
0Days
17If less than one day
hrs. min.

9. Birthplace

Mass.

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

12. Name Elias DeSylva

13. Birthplace Mass. (dec)

14. Maiden name Bessie Dickson

15. Birthplace Scotland

16. Informant husband: Milo D. McMillan

Address 126 E. Wilson St., Indian Head, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12-16-46

(month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Virginia

18. Funeral director W.W. Chambers

Address 1400 Chapin St. NW Wash. D.C.

12-14 46

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Prince George

City or town Indian Head

(If outside city or town limits, write RURAL and give nearest town)

Street No. 126 East Wilson Road.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Dec.

19 46 at 10:12a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Dec. 19 46 to 13 Dec. 19 46

and that I last saw h. in alive on 13 Dec. 19 46

Immediate cause of death Congestive heart failure

Due to Valvular Rheumatic heart disease mitral stenosis & insufficiency

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results advanced mitral stenosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

C. T. S. BARNES, Lt. Cdr. (MC) USN

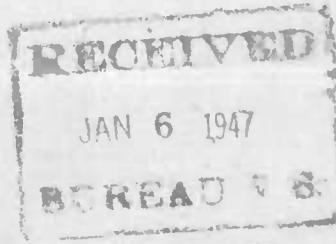
M. D. or other

12-14-46

23. SIGNATURE

Address USNH Bethesda, Md.

Date signed



2-25

2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

12570
216

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

9 hours

3. (a) FULL NAME

McWILLIAM, Samuel James

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male W-US married

6.(b) Name of husband or wife..... Mrs. Beatrice McWilliam

7. Birth date of deceased (mo., day, yr.)..... Feb. 16, 1875

6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
71 9 16 hrs. min.

9. Birthplace..... No. (Town, county, and state)

10. Usual occupation..... retired judge

11. Industry or business

12. Name..... Benjamin McWilliam,
13. Birthplace..... Pa. (dec)MOTHER FATHER
14. Maiden name..... Mary Cloud
15. Birthplace..... Pa. (dec)

16. Informant..... wife: Mrs. Beatrice McWilliam

Address..... 5730 1st St., N. W., Wash., D.C.

17. burial..... Date thereof..... 12-5-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Arlington National
Location..... Arlington, Va.

18. Funeral director..... S. H. HINES,

Address..... 2900 14th St., N.W., Wash., D.C.

19. 12-2 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 5730 1st St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war..... 1st World War

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 2 Dec. 1946 at 2:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2 Dec. 1946 to 2 Dec. 1946

and that I last saw h. i.m. alive on 2 Dec. 1946

Immediate cause of death.....

Cerebral hemorrhage

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Massive cerebral hemorrhage at the base
Autopsy results of the brain also marked cardiac
PHYSICIAN: Please underline the cause to which death should be charged statistically.
hypertrophy.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Frank J. Broschart, M.D. (Signature)
Frank J. Broschart, M.D. (Signature)
Deputy Med. Examiner M. D. or other

Address..... Gaithersburg, Md. Date signed..... 12-2-46

RECEIVED

DEC 10 1946

BIRDS

2-25

2-2168 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The older age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12591

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 139 days

Hospital, institution, or street address where death occurred:

USNH Bethesda, Md.

How long in hospital or institution?..... 139 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Penn. County.....

City or town..... Readley Park

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 108 Delaware Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war..... World War I and II

3. (a) FULL NAME

MOORE, Frederick Houston

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married (divorced)

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... June 19, 1899

6.(c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
47	6	8	hrs. min.

9. Birthplace..... Kentucky

(Town, county, and state)

10. Usual occupation..... Ret USMC (Stock Clerk)

11. Industry or business

12. Name..... Joel Moore

13. Birthplace..... Kentucky

14. Maiden name..... Mary Thomas

15. Birthplace..... Kentucky

16. Informant..... Daughter: Mrs E.E. Hasmer

Address 108 Delaware Ave. Readley Pk. Pa.

17. Burial..... Date thereof..... 12-31-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Va.

18. Funeral director..... W.W. CHAMBERS (F.W. Seone.)

Address 1400 Chapin St. N.W. Washington, D.C.

19. Date rec'd by registrar..... Dec 28 1946

(Date rec'd by registrar) Mary Charlotte Smith, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 27 Dec. 1946, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9 August 1946, to 27 Dec. 1946

and that I last saw him alive on 27 Dec. 1946

Immediate cause of death.....

Carcinoma pharynx

DURATION
Indef.

Due to.....

Kitselman

Due to.....

Pulmonary tuberculosis
Cardiac infarction

(Include pregnancy within 8 months of death)

Major findings of operations.....

Carcinoma pharynx

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

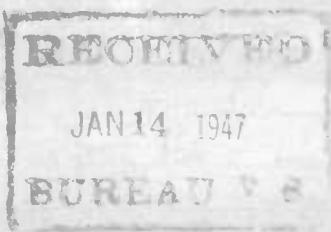
23. SIGNATURE..... A.J. DELANEY CAPT (MC) USN

Address USNH Bethesda, Md.

M. D. or other

12-28-46

Date signed



2-25

2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

12248

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 21 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 21 days

3. (a) FULL NAME

MOORE, Herbert Edwin

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	widowed

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)..... 24 July 1877

8. AGE: Years	Months	Days	If less than one day
69	9	9	hrs. min.

9. Birthplace..... Pa. (Town, county, and state)

10. Usual occupation..... Retired from Railroad

11. Industry or business.....

12. Name..... Herbert Moore

13. Birthplace..... England dec.

14. Maiden name..... Emma Millward

15. Birthplace..... Pa. dec.

16. Informant son: Herbert M. Moore

Address 915 Butternut St., N.W., Wash., D.C.

17. removal Date thereof..... 12-3-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Oddsfellow

Location..... Saint Clair, Pa.

18. Funeral director..... W. W. Chambers

Address 1400 Chapin St., N. W. Wash., D.C.

19. 12-3-46 Mary Charlotte Smith
(Date rec'd by registrar) Registrars

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)Street No..... 915 Butternut St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war..... Spanish American War

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 3 Dec. 1946 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9 1946 to 3 Dec. 1946, and that I last saw him alive on 3 Dec. 1946.

Immediate cause of death..... Cerebral hemorrhage
Due to..... Cerebral arteriosclerosisOther conditions..... arr. fibrillation & congestive heart failure
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results..... some
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of Injury..... Injured at work?

23. SIGNATURE..... C. W. THOMPSON, Lt.Cdr. (MC) USNR
M. D. or other

Address USNH Bethesda, Md. Date signed 12-3-46

RECEIVED

DEC 10 1946

BURRAT 16

2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

12249

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County.....

7 Lock Rd Callis Johnson

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Louise J. Morgan

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

B.(b) Name of husband or wife.....

Jerrold Morgan

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years
1900

8. AGE:

Years
46

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

MOTHER FATHER

12. Name.....

Frank Walker

13. Birthplace

Va

14. Maiden name.....

Louisa Hopper

15. Birthplace

Va

16. Informant.....

Jerrold Morgan

Address.....

7 Lock Rd

Burial

Date thereof..... Dec. 24, 1946
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Union Baptist Cem.

Location.....

Conduit Rd. D.C.

18. Funeral director.....

W Ernest Jones Co

Address.....

1432 2nd St NW

19. (Date rec'd by registrar)

12-20-46

19-

Reg. D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

7 Lock Rd Callis John Med

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 20 1946 5 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec. 19 1946 to Dec. 20 1946

and that I last saw h... u... alive on Dec. 20 1946

Immediate cause of death.....

Cerebral Hemorrhage

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

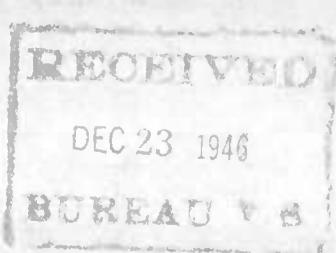
Means of Injury.....

Injured at work?

23. SIGNATURE.....

J. A. Dunn M. D. mother

Bethesda Md. Date signed 12-20-46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 870

12250

CERTIFICATE OF DEATH

Reg. Dist. No. 2180

1. PLACE OF DEATH: Montg Co,
 County Galtersburg, Md, Rural
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yr 6 mo
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Montg
 City or town Galtersburg, Md, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)**3. (a) FULL NAME**

Addison Lennard Painter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married
6.(b) Name of husband or wife Mabel L Painter		
7. Birth date of deceased (mo., day, yr.) Jan 17th 1883		
6.(c) If alive, give age 50 years		

 8. AGE: Years Months Days It less than one day
 1883 63 10 15 hrs. min.

 9. Birthplace Luckett, Va.
 (Town, county, and state)
 Farmer

10. Usual occupation

11. Industry or business

 12. Name Addison L Painter
 13. Birthplace Va,

 14. Maiden name Laverta Painter
 15. Birthplace Va,

 16. Informant Mrs Ernest Mills
 Address Galtersburg, R F D, #3

 17. Burial Date thereof 12/4/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Darnstow Cemetery

Location Darnstow, Md,

18. Funeral director Ernest C Gartner

Address Galtersburg, Md,

 19. Dec 2 1946 A. M. G. Baker
 (Date rec'd by registrar)
MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2nd 1946 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1945 to Dec 2 1946

and that I last saw him alive on Dec 1 1946

Immediate cause of death Parkinson Paralysis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)?

Means of injury Injured at work?

23. SIGNATURE A. M. G. Baker, M.D.

M. D. or other

Address Galtersburg, Md Date signed Dec 4/6

RECEIVED

DEC 4 1946

H. READ P. S.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12251

CERTIFICATE OF DEATH

Reg. Dist. No.

5140

1. PLACE OF DEATH:

County Montgomery

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 23 days

3. (a) FULL NAME

Emilie Norton Perry

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Fe. Cauc. married

6. (b) Name of husband or wife William E. Perry

7. Birth date of deceased (mo., day, yr.) Feb. 18 1884

6. (c) If alive, give age

years

8. AGE: Year 62 Months 9 Days 19 It less than one day hrs. min.

9. Birthplace Brandt Station, Va.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Benjamin Faulconer

13. Birthplace Orange, Va.

14. Maiden name Mary Margaret Johnson

15. Birthplace Brand, Va.

16. Informant Records - Washington San. & Hosp.

Address Takoma Park, Md.

17. Burial, cremation, or removal, Which? Date thereof DEC. 9-1946

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Bradensburg Rd., Prince George's Co., Md.

18. Funeral director Wm. E. Pumphrey

Address Silver Spring - Mo.

19. Dec 9 1946 Josephine M. Schaeffer

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town Silver Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No. 820 Bonifant St.

(If rural) give LOCATION

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7

1946, at 1¹⁵ A.M.

21. I CERTIFY that death occurred on the date above related; that I attended deceased from Nov. 14 1946 to Dec. 7, 1946 and that I last saw her alive on Tucson, Dec. 2, 1946.

Immediate cause of death

Gen-Carcinomatosis of the cecum & mesentery
Due to Carcinoma of Pancrease 2 yrs.
Due toOther conditions Hypertension, terminal uremia and cerebral edema
(Include pregnancy within 3 months of death)

Major findings of operation Ca. of cecum with obstruction and Ca. of mesentery Date of op. 11-19-46

Autopsy results as above 12-7-46

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Read n-Calvert Ave

M. D. or other

Address Silver Spring, Md. Date signed 12-7-46

RECEIVED

DEC 11 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-B

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

12252

1. PLACE OF DEATH:

County Bethesda Suburban Hosp.
City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49

Hospital, institution, or street address where death occurred:

Suburban Hospital, Bethesda, Md.How long in hospital or institution? Nov 4, 1946 to Dec 1, 1946

3. (a) FULL NAME

Melissa Jane Pollard

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

Female White Married

B. (b) Name of husband or Frank Pollard

7. Birth date of deceased (mo., day, yr.)

March 18, 1889

6. (c) If alive, give age 57 years

8. AGE:

Years

Months

Days

If less than one day

57

9

28

hrs.

min.

9. Birthplace Brookville, Mont. Co.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business None

MOTHER FATHER

12. Name Solomon E. Yearley13. Birthplace Baltimore, Md.14. Maiden name Melissa Samuels15. Birthplace Iowa16. Informant James ChristopherAddress 4836 Bradley Blvd. Ch. Ch. Md.

17. (Burial, cremation, or removal. Which?)

Date thereof Dec 18, 1946

(month) (day) (year)

Cemetery or crematory ST. MARY'S CEMETERYLocation Rockville - Md.18. Funeral director WM. REUBEN PUMPHREYAddress BETHESDA - Md.19. 12/17 1946
(Date rec'd by registrar)

21m E. Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville (If outside city or town limits, write RURAL and give nearest town)Street No. Wall St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-18-8524

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 16 1946 at 10:34 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Aug 1st 1946 to Dec 16, 1946and that I last saw her alive on Dec 16, 1946Immediate cause of death Lymphosarcoma

involving mediastinal lymph nodes

thoracic lymph nodes & metastasis

to other areas. Large terminal

Bul. fo. hemorrhage into gastro intestinal

Due to Tumor Tarry stoolOther conditions Gastric anemia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. Dec 16, 1946Autopsy results See above findings

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State) —Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE C E Hanks

M. D. or other

Address Oak Hill Rd Date signed 12/16/46

RECEIVED

DEC 23 1946

BUREAU F.B.I.

2 - 35

RECEIVED

DEC 28 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94(a)

12254

Reg. Dist. No. 2181

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Montg Co.

City or town CLARKSBURG (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

NORMAN RAINTERS

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Single

6.(b) Name of husband or wife: _____

7. Birth date of deceased (mo., day, yr.) Unknown, About 1882

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
1882 64 hrs. min.9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Edward Rains

13. Birthplace Va,

14. Maiden name Mary Rains,

15. Birthplace Va,

16. Informant Della Anderson

Address 800 G-St. N E, Washington D

Burial 12/27/46

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Hyattstown Cemetery

Location Hyattstown, Md,

18. Funeral director Ernest C Gartner

Address Fairthorpe, Md,

19. Dec. 26, 1946 Abigail L Cooke
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg Co.

City or town Clarksburg (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH unknown, 19..... at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept med Jan 19..... to..... 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death: _____

Coronary occlusion

Due to: _____

Due to: _____

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____

Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

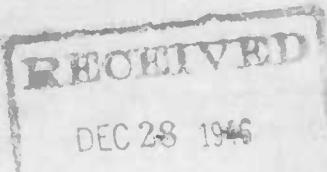
Means of injury: _____

Injured at work? _____

23. SIGNATURE: _____

Dec. 26, 1946 Frank J. Bronhardt M.D. or other

Address: Fairthorpe, Md Date signed: 12-26-46



AMERICA

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

12255

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County

Montgomery

City or town

Bethesda Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Since Dec. 23, 1946

Hospital, Institution, or street address where death occurred:

Suburban Hosp., 8600 Old Georgetown Rd.

How long in hospital or institution?

Bethesda Md

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

City or town

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

31 Carroll Ave

(If rural, give LOCATION)

3. (a) FULL NAME

Mrs Margaret F. Ray

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

6. (b) Name of husband or wife

Edward Burton Ray

7. Birth date of

deceased (mo., day, yr.)

February 5, 1861

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

55

10

23

hrs.

min.

9. Birthplace

Pittson, Pennsylvania

(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

James Scott

12. Name

James Scott

13. Birthplace

Unknown

14. Maiden name

Mary Burns

15. Birthplace

Unknown

16. Informant

Miss Bird, daughter

Address

829, Twenty St N.W. DC

17. Burial, cremation, or removal

Burial

Date thereof (month) (day) (year)

Cemetery or crematory

Philadelphia

Location

Philadelphia

18. Funeral director

Huntersman Funeral Home

Address

5732 Ga ave N.W.

19. (Date rec'd by registrar)

12/28 1946

John E. Jones
Registrar

(Date rec'd by registrar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1946, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 23, 1946, to December 28, 1946,

and that I last saw her alive on December 28, 1946.

Immediate cause of death Bronchogenic carcinoma

DURATION

5 days

Due to Diabetes mellitus
and hypertension heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

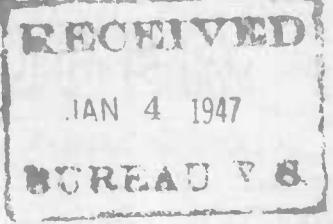
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Barbara Mayton M.D.

M. D. or other

Address Suburban Hospital Date signed 12-28-1946



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

12256

CERTIFICATE OF DEATH

Reg. Distr. No. 2180

1. PLACE OF DEATH: Montg Co,
County.....
City or town..... Gaithersburg, Md, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Montg
City or town..... Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

3. (a) FULL NAME

Jannie Jane Reed
4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife George Reed
7. Birth date of deceased (mo., day, yr.) April 25th 1880
6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
1880 66 7 20 hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER 12. Name Armonas Gray
13. Birthplace Va,

MOTHER 14. Maiden name Annie Kerse
15. Birthplace Va,

16. Informant Harvey Reed
Address Gaithersburg Md

Burial Burial Date thereof 12/17/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg Md

18. Funeral director Ernest C Gartner
Address Gaithersburg Md

19. Dec-16 1946 Absent L. Cooke
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15th 1946 at 5:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. med. exam. case 19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

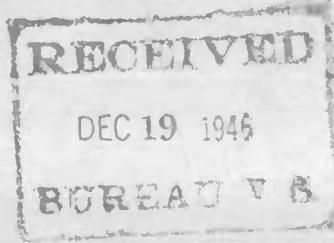
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brachard M.D.

Dif. med. exam. M. D. or other

Address Gaithersburg Md Date signed 12-18-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 250

CERTIFICATE OF DEATH

12257
3160

Reg. Dist. No.

1. PLACE OF DEATH:

County... Montgomery
City or town... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Nov. 29, 1946

Hospital, institution, or street address where death occurred:

Suburban Hosp. - 8600 Old Georgetown Rd

How long in hospital or institution? Since Nov. 29, 1946 Bethesda Md.

3. (a) FULL NAME

Mrs Mary C. Renshaw

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

6. (b) Name of husband or wife

William Renshaw (Deceased)

7. Birth date of deceased (Mo., Day, yr.)

August 17, 1867

6. (c) If alive, give age..... years

8. AGE:

Years 79 Months 4 Days 9 if less than one day hrs. min.

9. Birthplace... Luray, Virginia

(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

12. Name... Ambros Moyer

13. Birthplace... Luray, Virginia

14. Maiden name... Elizabeth Stomback

15. Birthplace... Luray, Virginia

16. Informant... Mrs. Leonard Morrison

Address... Bethesda, Maryland

17. Burial

Date thereof... 12/28/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rockville Union Cemetery

Location... Rockville, Maryland

18. Funeral director... Wm. Henley Humphrey
Address... 7557 Wis. Ave. Bethesda, Maryland19. 12/28/46
(Date rec'd by registrar)

Wm E Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...

City or town... Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4602 Montgomery Ave,

(If rural, give LOCATION)

2. (a) If veteran, name war...

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1946 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1, 1946, to Dec 26, 1946, and that I last saw her alive on Dec. 25, 1946.

Immediate cause of death... Bronchitis - pneumonia and Cardiac Decomposition

Due to... Generalized Enteritis

Due to...

Other conditions... Appendicitis

(Include pregnancy within 3 months of death)

Major findings or operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

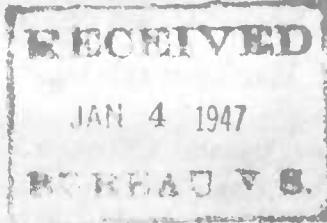
Means of Injury

Injured at work?

23. SIGNATURE... W. J. Jones

M. D. or other

Address... 546 Single Rd, Bethesda, Md. Date signed... 12-26-46



ML 6551

judgment entered below

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12258

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 2170

1. PLACE OF DEATH: Montgomery
County.....
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME John F Riggs

4. Sex Male 5. Color or race AA. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mamie E Riggs

7. Birth date of deceased (mo., day, yr.) June 30 1873 6.(c) If alive, give age 99 years

8. AGE: Years 73 Months 5 Days 26 11 less than one day hrs. min.

9. Birthplace Montgomery County, Md.
(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business

12. Name Samuel A. Riggs

13. Birthplace Montgomery Co. Md

14. Maiden name Mary Anne Fisher

15. Birthplace Hanover County, Md.

16. Informant Bradley Riggs (son)

Address Norbeck, Md.

17. Burial Date thereof Dec 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Church Cemetery

Location Norbeck, Md.

18. Funeral director R. L. Snodderly

Address Rockville, Md.

19. F-2 - 28 - 1946 Bestard & Lawley

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Montgomery

City or town Oakdale (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1946, at 8:08 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1946, to December 26, 1946, and that I last saw him alive on December 25, 1946.

Immediate cause of death.....

Massive Coronary Thrombosis, circ.

Due to Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

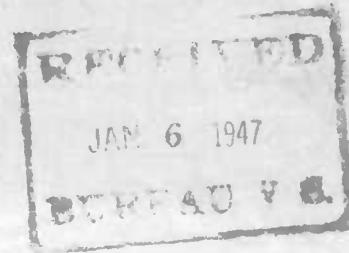
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Welles Sowell M.D. M. D. or other

Date signed 12-28-46

Address Norbeck, Md.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

8712259

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

4 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

Maryland County.....

City or town.....

Bethesda (If outside city or town limits, write RURAL and give nearest town)

Street No.....

6800 Fairfax Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

Mrs - Anna F. Ring

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white married

6.(b) Name of husband or wife.....

Andrew

7. Birth date of
deceased (mo., day, yr.)

Sept. 2, 1905.

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

41

3

18

hrs. min.

9. Birthplace.....

Berkley Springs, W. Va.

(Town, County, and state)

10. Usual occupation.....

11. Industry or business

P.M. Appel

12. Name.....

Unknown

13. Birthplace.....

Unknown

14. Maiden name.....

Lanta

15. Birthplace.....

Unknown

16. Informant.....

A. D. Ring (husband)

Address.....

Same

17. Burial.....

Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Endow Hill

Location.....

Md

18. Funeral director.....

S. H. Jones Co.

Address.....

Washington D.C.

19. (Date read by registrar)

1/21/46

Registrar.....

John E. Johns

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 20 1946 at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 1946 to Dec. 20 1946

and that I last saw h... ex. alive on Dec. 20 1946

Immediate cause of death.....

Cerebral hemorrhage 9 hrs.

Due to..... Generalized arteriosclerosis

and high hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Richard V. Mattingly M.D.

M. D. or other

Address..... 4707 Corcoran Ave. NW Wash. DC Date signed 12/20/46

RECEIVED

DEC 23 1946

BUREAU OF ECONOMIC INFORMATION

1-55-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 469

12260

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County... Montgomery
City or town... Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Dec, 19, 1946

Hospital, Institution, or street address where death occurred:

Suburban Hosp. - 8600 Old Georgetown Rd.,

How long in hospital or institution? Since Dec, 1946 - Bethesda

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montg.
City or town... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9509 Baltimore Drive
(If rural, give LOCATION)

3. (a) FULL NAME

Mr Charles T. Robinson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

6. (b) Name of husband or wife... Miriam Robinson

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1900

8. AGE: Years Months Days If less than one day
46 10 25 hrs. min.

9. Birthplace... Washington D.C.
(Town, county, and state)

10. Usual occupation... Taxi Driver

11. Industry or business

12. Name... Noah R. Robinson

13. Birthplace... ? N.C.

14. Maiden name... Lois Garwood Willis

15. Birthplace... ? N.C.

16. Informant... Mrs. B. S. wife

Address... Mrs. Miriam Robinson S. S. #

17. Burial Date thereof... 12-24-46
(Burial, cremation, or removal, if any?) (month) (day) (year)

Cemetery or crematory... Glenwood

Location... Maude D.C.

18. Funeral director... Warner E. Lumpkin

Address... 8434 Ge Ave Silver Spring

19. 12/22/46 7pm 5 p.m.
(Date rec'd by registrar)

3. (b) Social Security Number

572389400

MEDICAL CERTIFICATION

2d. DATE OF DEATH December 22 1946 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1937 to Dec 22 1946 and that I last saw him alive on December 22 1946.

Immediate cause of death

Cerebral Emboli (Stroke) 3 days

Due to... Bacterial Endocarditis 15 days

Due to...

Other conditions Cysticoma of Body of Pancreas
or Melanoma to Liver
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results... Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... — Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W.B.Wardig Jr. M.D. or other

Address... 943 Bonfield St. Date signed... 12/22/46

Dulles, Virginia

RECEIVED

DEC 28 1946

BUREAU V S

2-35

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Montgomery

Registration Dist. No.

Village or City Takoma Park, Maryland

No. Washington Sanitarium & Hospital Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mrs. Allie V. Sasnett

P.C. If U. S. Veteran, specify WAR

(a) Residence: No. 34 Chillum Rd., Hyattsville, Md.

Ward.

If nonresident give city or town and State

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Female

White

Divorced

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mr. R. W. Sasnett

6. DATE OF BIRTH (month, day, and year) July 17, 1897

7. AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

49

4

23

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.

Housewife

9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.

Own Home

10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)

Alabama

MOTHER FATHER

13. NAME

William Baxley

Date of onset

14. BIRTHPLACE (city or town)
(State or country)

Alabama

1944

15. MAIDEN NAME

Emma Williams

16. BIRTHPLACE (city or town)
(State or country)

Alabama

17. INFORMANT Hospital Records & Daughter
(Address)

18. BURIAL, CREMATION, OR REMOVAL

Piece

Date 12/10, 1946

19. UNDERTAKER A. H. Hines Co.
(Address) 2901-14th St. N.W. Wash. D.C.

20. FILED Dec. 10, 1946

Registrar.

46-24

12261
2230No. Washington Sanitarium & Hospital Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

If U. S. Veteran, specify WAR

(a) Residence: No. 34 Chillum Rd., Hyattsville, Md. Ward.

If nonresident give city or town and State

21. DATE OF DEATH

Dec.

10

1946
(Month)
(Day)
(Year)

22. I HEREBY CERTIFY. That I attended deceased from

Jan. 1, 1946, to Dec. 10, 1946. He was alive on Dec. 9, 1946, death is said

to have occurred on the date stated above, at 3:28 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Carcinoma of the
Rectum

Other Contributory Causes of importance:

Name of operation Colostomy Date of 8/19/44

What test confirmed diagnosis Tissue Exam Was there an autopsy? NO

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed)

Hollywood Regis M. D.

(Address) 1020 Pinney Dr. Rockville, Md.

D.A. WASH-D.C.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	RECEIVED 1 week ago
Run over by street car	1 week ago

RECEIVED
DEC 11 1946

RECEIVED
DEC 11 1946

Other contributory causes of importance:

Gallstones	May 1, 1923

Other contributory causes of importance:

Gastroenteritis	1-35 1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462+

CERTIFICATE OF DEATH

2263

216

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 days

Hospital, Institution, or street address where death occurred:

USNH Bethesda, Md.

How long in hospital or institution?..... 5 days

3. (a) FULL NAME

SCHAFFER, Donald Norton Capt. USNR Active

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Male W-US Married

6. (b) Name of husband or wife..... Mrs. Virginia Schaffer

7. Birth date of deceased (mo., day, yr.)..... 6. (c) If alive, give age years
3-6-038. AGE: Years Months Days If less than one day
43 9 19 hrs. min.9. Birthplace..... Vermont
(Town, county, and state)

10. Usual occupation..... Navy

11. Industry or business

12. Name..... John R. Schaffer

13. Birthplace..... Penna

14. Maiden name..... Hannah Masland

15. Birthplace..... Penna.

18. Informant..... Wife: Mrs. Virginia Schaffer

Address..... 10 Farraget Ave. Kensington, Md.

11. Burial..... Date thereof..... 12-17-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Virginia

18. Funeral director..... W. W. CHAMBERS R.S.M.

Address..... 1100 Chapin St., N. W., Wash. D. C.

19. 15 Dec. 1946
(Date rec'd by registrar)Mary Charlotte Smith
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Kensington
(If outside city or town limits, write RURAL and give nearest town)Street No..... 10 Farraget Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 15 December 1946 at 1130 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 1946 to Dec. 15 1946

and that I last saw h. in alive on 15 Dec. 1946

Immediate cause of death..... Hepatic failure

DURATION
3 wksDue to..... massive
metastatic carcinoma
of liver descending colon
duodenal carcinoma of sigmoid

indet

Other conditions..... Obstructive jaundice
collapse both lower lobe
metastatic carcinoma to blood vessels of lungsincldo pregnancy within 3 months of death
defMajor findings of operations..... metastatic carcinoma
of liver Date of op. 12/13/46

Autopsy results..... as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... J.C. OWENS LT. COMDR. USN
M. D. or other

Address..... USNH Bethesda, Md. Date signed 12-17-46

RECEIVED

JAN 6 1947

BUREAU U.S.

2-25

2-2160-2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

12262

CERTIFICATE OF DEATH

Reg. Dist. No. 2180

1. PLACE OF DEATH:

County MontgomeryCity or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 1/2 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Gustave Scharf

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 9, 1877 6.(c) If alive, give age years8. AGE: Years 69 Months 8 Days 14 If less than one day hrs. min.9. Birthplace Philadelphia, Pa.
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Rev. John G. Scharf13. Birthplace Wurtenburg, Germany14. Maiden name Sarah Koffel15. Birthplace Penn.16. Informant Miss Elizabeth ScharfAddress All States Inn, Rockville, Md.
Burial Date thereof 12/26/46(Burial, cremation, or removal. Which?) Fort Lincoln CemeteryCemetery or crematory MarylandLocation Maryland
18. Funeral director Wm Acuban PurnfreyAddress 7557 Wis. Ave., Bethesda, Maryland19. Date rec'd by registrar Dec 26 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Gaithersburg (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1946 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Dec 22 1946 Immediate cause of deathCerebral myocarditis

Due to

Emphysema

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

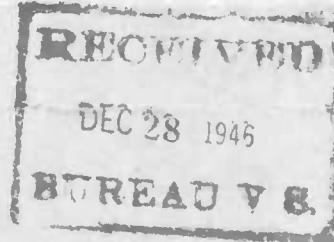
Means of injury

Injured at work?

23. SIGNATURE F.J. Brontat M.D.

M. D. or other

Address Gaithersburg, Md. Date signed Dec 23 1946



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12592

1640

CERTIFICATE OF DEATH

Reg. Distr. No. 2161

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

1 hour

How long in above place of death?

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Ohio

State County Willoughby

City or town (If outside city or town limits, write RURAL and give nearest town)

41 Buckeye Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

SCHMIDT, Edward Jr., Pfc USMC

3. (b) Social Security Number

4. Sex male	5. Color or race W-US	6.(a) Single, married, widowed, or divorced married
----------------	--------------------------	--

6.(b) Name of husband or wife Mrs. Norah K. Schmidt

7. Birth date of deceased (mo., day, yr.) May 24, 1928

6.(c) If alive, give age years

8. AGE: Years 18	Months 7	Days 16	If less than one day hrs. min.
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9. Birthplace Ohio
(Town, county, and state)

10. Usual occupation Marine Corps

11. Industry or business

12. Name Edward Schmidt, Sr.
13. Birthplace Ohio

14. Maiden name Irene Musetta Schmidt
15. Birthplace Ohio

16. Informant wife: Mrs. Norah K. Schmidt

Address 2127 15th St., N.W., Wash., D.C.
removal Date thereof 12-31-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Willoughby, Ohio

Location

18. Funeral director W. W. CHAMBERS

Address 1100 Chapin St., N.W., Wash., D.C.

19. 12-30 1946 Mary Charlotte Smith
(Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Dec. 1946 at 11:05 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

30 Dec. 1946 to 30 Dec. 1946

and that I last saw him alive on Dec. 30, 1946

Immediate cause of death

Inter-cranial hemorrhage

Due to bullet wound thru skull

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 12-30-46

Where did injury occur? Washington, D.C. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Ridge Rd.

Means of injury Injured at work?

23. SIGNATURE Frank J. Brookhart M.D.

Died from Excessive

M. D. or other

Address Gaithersburg, Md. Date signed 12-30-46

RECEIVED

JAN 10 1947

BUREAU OF INVESTIGATION

2-25

2-2160 - 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The accuracy
is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change
year of birth is shown on
G 108 1/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a *

12593

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since June 29-1945

Hospital, institution, or street address where death occurred:

Waverley Sanitarium Since June 29-1945

How long in hospital or institution?

3. (a) FULL NAME

Robert John Service

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife Mary Logan Coldwell

Service

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Feb. 20 1887/4 1876

8. AGE: Years 70 Months 9 Days 26 It less than one day - hrs. - min.

9. Birthplace Austin Minnesota

(Town, county, and state)

10. Usual occupation Tax Expert

11. Industry or business U.S. Government

12. Name John H. Service

13. Birthplace Canada

14. Maiden name Roxana Mac Kellar

15. Birthplace Iowa

16. Informant Daughter Ruth Stidham

Address 2826 - Albermarle St. N.W.

17. Burial Date thereof 12/14/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cem.

Location Arlington, Va.

18. Funeral director Wrenna Murphy

Address 7557 Wisconsin Ave., Bethesda

19. 12-13 1946 Date rec'd by registrar

Bettie Sander Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State:

County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

Locality:

City or town:

State:

Street No.:

Locality:

I MARGIN RESERVED FOR BINDING

131a *

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JAN 9 1947

BUREAU F.B.I.

2-35

21-81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12264

CERTIFICATE OF DEATH

Reg. Dist. No. 216. 1

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 33 hours

Hospital, Institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 33 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... County..... Washington, D.C.

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... 3331 Rhode Island Ave., N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

SIMPSON, Edward Franklyn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife..... Nova Simpson

7. Birth date of deceased (mo., day, yr.)..... 8 July 1874

8. AGE: Years Months Days If less than one day

72 4 26 hrs. min.

9. Birthplace..... Md. (Town, county, and state)

10. Usual occupation..... Retired Barber

11. Industry or business.....

12. Name..... Benjamin A. Simpson

13. Birthplace..... Md. dec.

14. Maiden name..... Ellen Van Luden Whintner

15. Birthplace..... Md. dec.

16. Informant..... wife: Mrs. Nova Simpson

Address..... 3331 Rhode Island Ave., N.E., Wash., D.C.

17. burial..... Date thereof..... 12-6-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Washington National

Location..... Washington, D.C.

18. Funeral director..... Wm. J. Nalley

Address..... 3200 Rhode Island Ave., N.E., Wash., D.C.

19. 12-4 146 Mary Charlotte Smith

(Date rec'd by registrar) 19..... Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1 Dec. 1946 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Dec. 1946 to 4 Dec. 1946

and that I last saw h. in alive on 4 Dec. 1946

Immediate cause of death.....

Disease..... GENERALIZED PURULENT PERITONITIS

Due to..... PERFORATED STOMACH ULCER

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... PERFORATED ULCER & GEN. PERITONITIS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

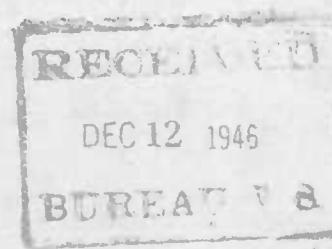
Means of injury.....

Injured at work?.....

23. SIGNATURE..... H. J. COKELEY, Capt. (MC) USN

M. D. or other.....

Address..... USNH Bethesda, Md. Date signed..... 12-1-46



2-25

2-2160 - 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12265

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH

County Montgomery
 City or town Cherry Chase Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ada Hainfin Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

Charles Sutton Smith

7. Birth date of deceased (mo. da. yr.)

Jan 5, 1904 6. (c) If alive, give age 45 years

8. AGE:

Years <u>42</u>	Months	Days	If less than one day hrs. min.
-----------------	--------	------	--

9. Birthplace

San Francisco
(Town, county, and state)

10. Usual occupation

Newspaper Writer

11. Industry or business

RECEIVED

DEC 19 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 109

CERTIFICATE OF DEATH

12266

2160

Reg. Diet. No.

1. PLACE OF DEATH:

County.....

City or town.....

Montgomery

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

32 1/2 hrs

3. (a) FULL NAME

Mrs. Ella Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife.....

Eliam

7. Birth date of deceased (mo., day, yr.)

Sept - 9, 1886

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Fort Snelling, Minn

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER

12. Name.....

Col. J. J. Van Horn

MOTHER

13. Birthplace.....

Mt. Risledo, Ohio

14. Maiden name.....

Margaret Wilson

15. Birthplace.....

Ogallala, Nebraska

16. Informant.....

Brother James H. Van Horn

Address.....

43 Hastings Rd. Belmont Mass

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(Month) (day) (year)

Cemetery or crematory.....

Arlington Nat. Cem

Location.....

" Va

18. Funeral director.....

Joseph Hawley Son Inc

Address.....

1056 Penna Ave. N. St.

19. 12/16/46 1946

(Date rec'd by registrar)

Wm E Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Broadway Apts

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec. 17, 1946, at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 16, 1946, to Dec. 17, 1946,

and that I last saw her alive on Dec. 17, 1946.

Immediate cause of death.....

LOBAR PNEUMONIA

BILATERAL, INVOLVING ALL Lobes

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... LOBAR PNEUMONIA

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Silver Spring, Md. Date signed..... 12-18-46

RECEIVED

DEC 23 1946

BUREAU V.B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

12267

2/18/1

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Goshen MD Rural Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... All day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Rosa May Snowden

4. Sex..... Female 5. Color or race..... Col 6.(a) Single, married, widowed, or divorced..... Widowed

6.(b) Name of husband or wife..... Willis E. Snowden

7. Birth date of deceased (mo., day, yr.)..... May 25, 1872 6.(c) If alive, give age..... years

8. AGE: Years..... 74 Months..... 6 Days..... 25 If less than one day..... hrs. min.

9. Birthplace..... Goshen MD (Town, county, and state)

10. Usual occupation..... House Wife

11. Industry or business..... Home

12. Name..... John F. Chase

13. Birthplace..... Germantown MD

14. Maiden name..... Miltilda Chase

15. Birthplace..... Germantown MD

16. Informant..... Miltilda Frazier

Address..... Gaithersburg MD

17. Burial..... Date thereof..... Dec 20, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Brook Grove MD

Location..... Montgomery Co. MD

18. Funeral director..... Roy W. Barber

Address..... Laytonsville MD

19. (Date rec'd by registrar)..... 1/1/49 H. O. Bell Regt. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Goshen Rural Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

none

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 17,

19 46 at 9 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 45 to Dec 16 19 46 and that I last saw her alive on Dec 16 19 46

Immediate cause of death.....

coronary thrombosis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Gaithersburg Date signed Dec 18 46

RECEIVED

DEC 24 1946

BUREAU F B I

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1-10

2-2180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(158)

12571

CERTIFICATE OF DEATH

Reg. Dist. No. 2140

1. PLACE OF DEATH:

County

Montgomery

City or town

Laurel md - R-2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lewis Stock

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

col

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct 22 1946

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Montgomery - MD

(Town, county, and state)

10. Usual occupation

—

11. Industry or business

—

MOTHER

FATHER

12. Name

Reuben Scott

13. Birthplace

VA

14. Maiden name

Bara Boyd

15. Birthplace

VA

16. Informant

Reuben Scott

Address

Laurel md - R-2

17. Burial

Cremation or removal? Which?

Date thereof

Dec 30 1946

(month) (day) (year)

Cemetery or crematory

Good Hope Cemetery

Location

Robert L Snodgrass

18. Funeral director

Roskville MD

Address

19. Dec 29

19. Y.C. Joseph M Schaeffer

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Street Maryland County

City or town Laurel - R-2

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 29

1946, at 5:30A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

N.Y.M.D. E.S. to

19.

and that I last saw h. alive on

19.

Immediate cause of death

Malnutrition

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J Broschart M.D. M.D. or other

Address

Gardening Rd Date signed 12-29-46

RECEIVED

JAN 2 1947

BUREAU OF

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 142

12268

CERTIFICATE OF DEATH

Reg. Distr. No. 216

1. PLACE OF DEATH,

County.....

Montgomery

City or town.....

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, Institution, or street address where death occurred:

4342 Montgomery Ave.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

John James Tantill Jr.

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

B. (b) Name of husband or wife

Edna Tantill

7. Birth date of deceased (mo., day, yr.)

March 10

B. (c) If alive, give age 45 years

8. AGE:

Years	Months	Days	If less than one day
50	9	11	hrs. min.

9. Birthplace

Anne Arundel Co. Maryland

(Town, county, and state)

10. Usual occupation

Lithographer

11. Industry or business

John James Tantill

MOTHER FATHER

John James Tantill

Madison, Va

Effie Russell

Madison, Ga

Perry M. Tantill

909 Mass Ave. N.E. Wash. D.C.

17.

(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory Frank Lincoln Crem

Location Wash. D.C.

S. X. Kliney G.

Address 2901-14th St. N.W.-Wash. D.C.

19. 12/21/46 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

Street No. 4342 Montgomery Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1946 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Evans care 19 to 19

and that I last saw h. alive on

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Boorhart M.D.

M. D. or other

Address 1000 Rockville Rd. Date signed 12-26-46

RECEIVED

DEC 23 1946

BUREAU OF INVESTIGATION

1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

12269

CERTIFICATE OF DEATH

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, institution, or street address where death occurred:

404 Holley Ave.

How long in hospital or institution?

3. (a) FULL NAME

Emma S. Denney4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1860 6. (c) If alive, give age years8. AGE: Years 87 Months Days If less than one day hrs. min.B. Birthplace New York, State (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Peter Schoonmacher13. Birthplace New York, State14. Maiden name Rachel Jane Merritt15. Birthplace New York, State16. Informant Tillman BunchAddress 310 W. Joppa Rd, Towson, Md.17. Removal Date thereof Dec. 31st, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Crematory, Cedar HillLocation Washington, D.C.18. Funeral director Joseph F. Birch's SonsAddress 3034 - M St., N.W., Wash., D.C.19. Dec. 31, 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. of Col. CountyCity or town Washington (If outside city or town limits, write RURAL and give nearest town)Street No. 3800 Woodley Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 15 - Dec. 31, 1946, to Dec. 31, 1946,and that I last saw her alive on Dec. 30, 1946.

Immediate cause of death.....

Congestive heart failure

Due to.....

artery - arteritis Indefinite

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. Shetty, M.D.M. D. or other SurgeonAddress 6911 5th St. NW Date signed 1/2/50

RECEIVED

JAN 3 1947

BTRFAC T S

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

Reg. Dist. No. 2170

12270

1. PLACE OF DEATH:

County MontgomeryCity or town Dolney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital, Inc.

How long in hospital or institution?

1 day

3. (a) FULL NAME

Dora Thomas

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

Colored

6.(b) Name of husband or wife

Wesley Thomas (deceased)

7. Birth date of deceased (mo., day, yr.)

March 18, 1881

6.(c) If alive, give age years

8. AGE:

Years
65Months
9Days
6

If less than one day

hrs.

min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Housework.

11. Industry or business

12. Name William Thomas Bellows13. Birthplace Colesville, Maryland14. Maiden name Mary Alberta Matthews15. Birthplace Colesville, Maryland16. Informant Hospital records.

Address

17. Burial Burial Date thereof Dec 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Gard House Ch. Cem.Location Colesville, Md.18. Funeral director R. L. StroudAddress 246 N. Wash. St., Rockville, Md.

19. 12-28-

1946 Heatmire-Lawler

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Silver SpringCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. Colesville

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1946 at 9:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23 1946 to December 24 1946 and that I last saw her alive on December 24 1946

Immediate cause of death

Kraemia

DURATION

6 days

Due to Chronic Interstitial Nephritis

?

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE JMB

M. D. or other

Address Sandy Spring, Md. Date signed 12/25/46

RECEIVED

DEC 31 1946

BUREAU OF

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Levad

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32-1

12271

CERTIFICATE OF DEATH

Reg. Dist. No.

2130

1. PLACE OF DEATH:

Montgomery
County

Rockville Maryland

(If outside city or town limits, write RURAL and give nearest town)

28 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

907 Maple Ave., Rockville, Maryland

How long in hospital or institution?

3. (a) FULL NAME

Mr. George Byron Trevey

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Ada A. Trevey

7. Birth date of deceased (mo., day, yr.)

September 18, 1872

(6. c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

74

3

6

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Jake Trevey

MOTHER FATHER

12. Name

Ada A. Trevey

13. Birthplace

Virginia

14. Maiden name

Victoria Harris

15. Birthplace

Maryland

16. Informant

Mrs. Ada A. Trevey

Address

Rockville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec 27/46

(month) (day) (year)

Cemetery or crematory

Presbyterian Church Cem.

Location

Darns Lodge - Maryland

18. Funeral director

Tom Prentiss Murphy

Address

Rockville, Maryland

19.

12-26-

1946

(Date rec'd by registrar)

Betty Jane Snyder

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State

Montgomery

County

Rockville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

907 Maple Ave.

Street No.

(If rural, give LOCATION)

No

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 24,

19 46 at 5:00 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1935

19 to Dec 23 - 1946

and that I last saw h. L.M. alive on Dec 23 - 1946

Immediate cause of death

Harmine poisoning

DURATION

4 da.

Due to Carcinoma of bladder

18 mo.

Due to Papilloma of bladder

10 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Upton & Young, A.D.

M. D. or other

Address Dawsonville Md Date signed Dec 25/46

RECEIVED

DEC 27 1946

BUREAU V.E.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

12272

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County... Montgomery County

City or town... Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Hours

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 9 Hours

3. (a) FULL NAME

Mr. Edward James Webster

4. Sex

m

5. Color or race

Wh-

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 3, 1868

6.(c) If alive, give age years

8. AGE: Years 78 Months 7 Days 2 If less than one day hrs. min.

9. Birthplace... Cincinnati, Ohio
(Town, county, and state)

10. Usual occupation... Retired

11. Industry or business R.R. Car Repair

12. Name... Isaac Webster

13. Birthplace Philadelphia, Pa -

14. Maiden name Alice Mc Cartey

15. Birthplace Steubenville, Ohio

16. Informant Washington Sanitarium Records

Address Takoma Park, Maryland

17. Removal Date thereof Dec. 5= 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington, D.C.

Location Location

18. Funeral director Jerry Lee Sons Co

Address 300-4th St. N.E. Room 801

19. Dec 5 1946 Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... District of Columbia County

City or town... Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6313 2nd St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

12/5/46 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 19 1946 to Dec 5 1946

and that I last saw him alive on Dec 4 1946

Immediate cause of death

Chronic degenerative arteriosclerosis

Due to Decomposition.

Due to Tumor left chest (Unknown)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Howard & Louise Smith M. D. or other

Address Takoma Park, Md. Date signed 12/5/46

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DEC 10 1946

BUREAU V-3

1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 370

12273

CERTIFICATE OF DEATH

Reg. Dist. No.

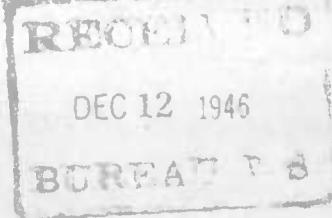
5141

M
**PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.**

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)				
How long in above place of death? Nearest town or street address where death occurred: 717 Richmond Ave.				
How long in hospital or institution?				
3. (a) FULL NAME A. FRANKLIN WILEY				
4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced male white widowed		
6.(b) Name of husband or wife..... Mary F.				
7. Birth date of deceased (mo., day, yr.) July 19th. 1869				
8. AGE:	Years 77	Months 4	Days 19	If less than one day hrs. min.
8. Birthplace..... Mass. (Town, county, and state)				
10. Usual occupation..... Retired				
11. Industry or business				
FATHER	12. Name..... Amos D. Wiley			
MOTHER	13. Birthplace..... Mass.			
14. Maiden name..... Lucinda Raymond				
15. Birthplace..... Mass.				
16. Informant..... Mrs. Norman C. Wiley				
Address 717 Richmond Ave. Silver Spg. Md.				
17. Removal & Burial Date thereof..... 12/10/1946 (Burial, cremation, or removal. Which?) Cemetery or crematory..... Riverside				
Location..... Winchendon, Worcester Co. Mass				
18. Funeral director..... Wayne E. Embrey Address..... Silver Spring, Md.				
19. Date rec'd by registrar..... Dec. 10, 1946 (Date rec'd by registrar)				

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
State..... Maryland County..... Montgomery City or town..... Silver Spring (If outside city or town limits, write RURAL and give nearest town)		
Street No..... 717 Richmond Ave. (If rural, give LOCATION)		
2.(a) If veteran, name war.....		
3. (b) Social Security Number		

MEDICAL CERTIFICATION		
20. DATE OF DEATH..... 8 December 1946 at 12 5 ^o P.M.		
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 December 1946 to 8 December 1946, and that I last saw him alive on 7 December 1946.		
Immediate cause of death..... Parkinson's Disease		
DURATION..... 11 years.		
Due to.....		
Due to.....		
Other conditions..... Arthritis, Herniated Disc and Kyphosis (Include pregnancy within 3 months of death) 8-10 years. 20-30 years.		
Major findings or operations..... Date of op. _____		
Autopsy results.....		
PHYSICIAN: Please underline the cause to which death should be charged statistically.		
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of _____		
Where did injury occur? (City or town) (County) (State)		
Injured at home, farm, industry, public place (where?)		
Means of injury Injured at work? _____		
23. SIGNATURE..... M. D. or other..... Address..... Takoma Park, Md. Date signed..... 8 Dec 1946.		



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MARGIN RESERVED FOR BINDING
 N. B.—WRITE PLENTY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

12274

1. PLACE OF DEATH

County Montgomery

Village or City Beallsville, Maryland

(34)

Registration Dist. No.

2130

St. Ward

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME MRS. SADIE N. WILLIAMS

If U. S. Veteran, specify WAR

(a) Residence: No. 25 Montgomery Ave. Kensington, Md.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

John T. Williams

6. DATE OF BIRTH (month, day, and year)

Dec. 18, 1884

7. AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Housewife

Date of onset

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)
(State or country)

Montgomery Co. Maryland

3 Mon

MOTHER FATHER

13. NAME Richard H. Cissel

14. BIRTHPLACE (city or town)
(State or country)

Montg. Co. Md.

3 yrs

15. MAIDEN NAME Julia Griffith

16. BIRTHPLACE (city or town)
(State or country)

Montg. Co. Md.

*I HEREBY CERTIFY. That I attended deceased from
Saw her Post Mortem to
on Dec. 24, 1946, summing up death
to have occurred on the date stated above, at 10 A.M.
The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:*

*acute Coronary occlusion 3 Mon
dangerous Reperfusion
General cerebral
ischaemic
vascular with Cardiac
vascular.*

Other Contributory Causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

17. INFORMANT Mrs. John R. Groft
(Address) 25 Montgomery Ave. Kensington, Md.18. BURIAL, CREMATION, OR REMOVAL
Place Monocacy Cem. Date Dec. 24, 1946

Beallsville, Md.

19. UNDERTAKER *H. R. Griffith*
(Address) Bethesda, Maryland20. FILED 12-24-1946 (Betty Jane Doyle
Registrar)

Manner of Injury _____

Nature of Injury _____

21. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) *Eugene J. Doyle* M. D.
(Address) *Baltimore County, Md.*

UNITED STATES STANDARD CERTIFICATE OF DEATH

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DEC 2 1946

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	Date of onset
Chronic interstitial nephritis	1915
Cerebral hemorrhage	1921

Date of onset

1915

1921

July 5, 1927

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	Date of onset
Run over by street car	1 week ago
Peritonitis	3 days ago

Date of onset

1 week ago

1 week ago

3 days ago

RECEIVED
DEC 27 1946

Other contributory causes of importance:

Gallstones	May 1, 1923
BUREAU V. B.	

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

CERTIFICATE OF DEATH

12275

Reg. Dist. No. 2140

1. PLACE OF DEATH:

County... Montgomery

City or town... Forest Glen, Maryland

(If outside city or town limits, write RURAL and give nearest town)

3 years

How long in above place of death?.....
Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

GEORGE HENRY WILLIS

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Muriel R. Willis

7. Birth date of
deceased (mo., day, yr.)

November 8, 1875

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

71

1

17

hrs.

min.

9. Birthplace.....

Washington, D. C.

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

12. Name..... William Willis

13. Birthplace..... Ireland

14. Maiden name..... Mary Shreve

15. Birthplace..... Maryland

16. Informant..... Mrs. Muriel R. Willis

Address..... Forest Glen, Maryland

17. Burial, cremation, or removal. Which?

Cremation

Date thereof..... 12/27/46
(month) (day) (year)

Cemetery or crematory..... Cedar Hill Crematory

Location..... Maryland

18. Funeral director..... Wm. Keeler Pumphrey

Address..... 7557 Wis. Ave. Bethesda, Maryland

19. Date rec'd by registrar..... Dec 26

(Date rec'd by registrar)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State..... County..... Montgomery

City or town..... Forest Glen, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

None

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 25, 1946

19... at 12:30 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 25 1946 to Dec. 25 1946

and that I last saw h. l. m. alive on Dec. 25 1946

Immediate cause of death.....

Cerebral hemorrhage

DURATION

6 hrs.

Due to..... Arteriosclerosis

Cardio vascular disease

unknown

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... none

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

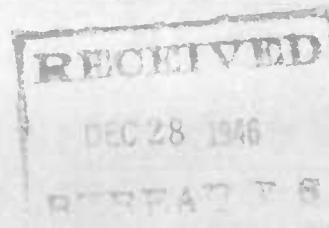
23. SIGNATURE

frank G. Beck M.D.

D. D. or other

Address..... 8248 Ga. Pop Silver Spring 12-2646

Date signed.....



1-35

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Line correct if necessary. Item especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1342

12276

CERTIFICATE OF DEATH

Reg. Dist. No. 216 /

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

2 months, 14 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2 months, 14 days

3. (a) FULL NAME

WISE, James Darwin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

W-US

married

Mrs. Nancy Wise

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) 29 March 1897

8. AGE: Years Months Days If less than one day

48 8 24 hrs. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual occupation unknown

11. Industry or business

12. Name Jim Wise

13. Birthplace N.C. (dec)

14. Maiden name Mary A. Sauls

15. Birthplace N.C. (dec)

16. Informant wife: Mrs. Nancy Wise

Address 1621 LaSalle Ave., Norfolk, Va.

17. removal Date thereof 12-23-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Lawn

Location Norfolk, Va.

18. Funeral director W. W. CHAMBERS

Address 1400 Chapin St., N. W., Wash. D. C.

19. 12-23 1946

Mary Charlotte Smith

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Va.

County

City or town

Norfolk

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1621 LaSalle Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

WW I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 December 1946 at 11:47 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 Oct. 1946 to 23 Dec. 1946 and that I last saw him alive on 23 Dec. 1946

Immediate cause of death PASSIVE CONGESTION AND EDema OF LUNGS
SUB ARACHNOID EDema OF BRAIN DURATION 3 days

Due to ANTERIOSCLEROTIC HEART DISEASE 5 years

Due to

Other conditions BILATERAL PYELONEPHRITIS
END STAGHORN CALCULI 10 yrs
(Include pregnancy within 3 months of death) STAG HORN

Major findings of operation BILATERAL STAGHORN CALCULI Date of op. 2 DEC 46

Autopsy results BILATERAL STAGHORN CALCULI

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

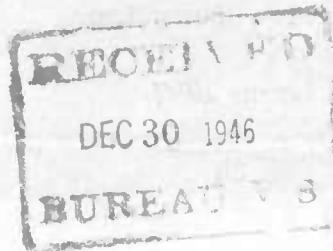
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. COKELEY, Captain (MC) USN M. D. or other

Address USNH Bethesda, Md. Date signed 12-23-46



2-25

2-2160 : _____

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

12277
2140

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Montgomery
Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

805 Maple Ave.

How long in hospital or institution? 6 mos.

3. (a) FULL NAME

Elizabeth Zee

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

November 17, 1867

5. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79

1

11

hrs.

min.

9. Birthplace

(Town, county, and state)

Virginia

10. Usual occupation

Housekeeper

11. Industry or business

at home

MOTHER FATHER

f2. Name

Joseph A. Zee

f3. Birthplace

Virginia

f4. Maiden name

Eleanor S. Gross

f5. Birthplace

Virginia

f6. Informant

Mrs. Eugenia Pallins

Address 4319 - 17th St., Arlington, Va.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 30, 46

(month) (day) (year)

Cemetery or crematory

Park Creek Cemetery

Location

Washington, D.C.

f8. Funeral director

J. H. Hines Co.

Address

2901 - 14th St., N.W. D.C.

19. Dec. 29

1946

Josephine M. Schaeffer

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C.

County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2108 - G St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war No.

3. (b) Social Security Number

No.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 29 46 2 40

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 12 46 to Dec. 29 46

and that I last saw her alive on Dec. 28 46

Immediate cause of death

Senility

Due to

Due to

Other conditions

Bronchopneumonia 4 days

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

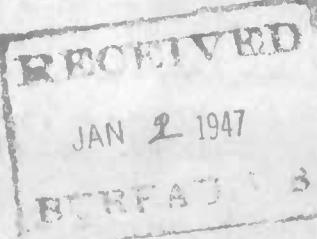
23. SIGNATURE

Alvmer J. Brown, M.D.

M. D. or other

45 Carroll Ave, Takoma Park

Date signed Dec. 29, 46



1-35